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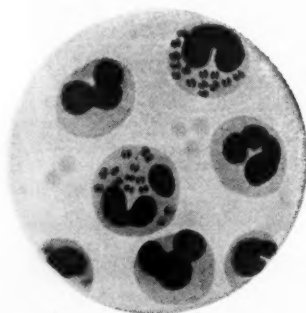
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- (1) Yow, E. M.; Taylor, F. M.; Hirsch, J.; Frankel, R. A., & Carnes, H. E.: *J. Pediat.* **42**:151, 1953. (2) Dodd, K.: *J. Arkansas M. Soc.* **10**:174, 1954. (3) Hanbery, J. W.: *Neurology* **4**:301, 1954. (4) Miller, G.; Hansen, J. E., & Pollock, B. E.: *Am. Heart J.* **47**:453, 1954. (5) Keefer, C. S., in Smith, A., & Wermer, P. L.: *Modern Treatment*, New York, Paul B. Hoeber, Inc., 1953, p. 65.

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# Meat...

## *and Its Contribution to Fat Needs*

Fat, the most concentrated source of nutrient energy, constitutes a dietary essential in human nutrition.<sup>1</sup> It is needed in growth and replacement of tissues, for specific lipid secretions, and for providing physiologic energy.<sup>1,2</sup> Absorbed fatty acids may be incorporated into more complex lipids, deposited in adipose tissue, converted into other fatty acids, used in production of milk fat, transformed into glucose or glycogen, or oxidized to carbon dioxide and water with liberation of energy.<sup>3</sup>

Evidence indicates that long continued extremely low fat intake in adults is incompatible with good health.<sup>4,a</sup> In addition to protecting tissue protein against catabolism for energy needs (the protein-sparing action of fat), sufficient amounts of fat in the dietary promote storage of protein.<sup>4,b</sup> In a normal mixed diet, fat is about 95 per cent as efficient as carbohydrate for production of muscular work.<sup>4,c</sup>

Neither the optimal level of fat in the diet nor the optimal range for apportionment of fat and carbohydrate to meet calorie allowances is known.<sup>1,2</sup>

Contrary to general impressions, fat in the mixed diet is effectively digested.<sup>4,d</sup> In moderate amounts it does not appreciably influence the digestibility of other foods.<sup>5</sup> Fat enhances the satiety value of meals, and foods naturally containing fat and those prepared with fat add much to the flavor value of meals. High fat diets sometimes are useful in alleviating constipation.<sup>6</sup>

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1. Goldsmith, G. A.: Application to Human Nutrition, in Bourne, G. H., and Kidder, G. W.: *Biochemistry and Physiology of Nutrition*, New York, Academic Press Inc., 1953, chap. 23, p. 505.
2. Recommended Dietary Allowances, Washington, D. C., National Academy of Sciences—National Research Council, Publication 302, 1953, p. 23.
3. Ekstein, H. C.: Fat in Nutrition, in *Handbook of Nutrition, A Symposium*, ed. 2, Philadelphia, The Blakiston Company, 1951, p. 23.
4. Sherman, H. C.: *Chemistry of Food and Nutrition*, ed. 8, New York, The Macmillan Company, 1952, (a) p. 30; (b) p. 198; (c) p. 115; (d) p. 103.
5. McLester, J. S., and Darby, W. J.: *Nutrition and Diet in Health and Disease*, ed. 6, Philadelphia, W. B. Saunders Company, 1952, pp. 130-135.
6. Smith, F. H.: The Use of High Fat Diets for Constipation, *J.A.M.A.* 88:628 (Feb. 26) 1927.
7. Okey, R.: Cholesterol Content of Foods, *J. Am. Dietet. A.* 21:341 (June) 1945.

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## SIMPLIFIED RULES FOR THE DIAGNOSIS OF CONGENITAL MALFORMATIONS OF THE HEART AMENABLE TO SURGERY\*

BENJAMIN M. GASUL, M.D.

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ABOUT ten years ago our knowledge and our ability to make a correct diagnosis of a congenital malformation of the heart was very limited. Nowadays, because of the knowledge gained by the clinician from angiocardiology, catheterization and from the experience in the operating room, there are an ever increasing number of physicians who can almost always decide whether a particular patient with a congenital malformation of the heart is amenable to surgery. All that is needed by the experienced clinician is to make a correlative study of the history and physical examination with the fluoroscopic, roentgenologic and electrocardiographic findings.

I am not going to give you an academic or complete discussion of this subject. I shall attempt to simplify this as much as possible and will show you a number of slides to illustrate my lecture.

### *Congenital Malformations of the Heart Amenable to Surgery*

#### A. Non-Cyanotic Type

##### GROUP I. Value of Surgery Established

1. Coarctation of the aorta
2. Patent ductus arteriosus
3. Double aortic arch or some other abnormality of the arch
4. Isolated pulmonary stenosis
5. Pulmonary stenosis with interauricular communication

##### GROUP II. Value of Operations Debatable

1. Interauricular septal defect
2. Lutembacher's syndrome
3. Aortic and subaortic stenosis

4. Aortic septal defect
5. Anomalous origin of left coronary artery from the pulmonary artery
6. Anomalous drainage of all pulmonary veins
7. Triatrial heart (a double left auricle)
8. Pericardial defects
9. Pulmonary stenosis with interventricular septal defect

#### B. Cyanotic Type

##### GROUP 1. Value of Operation Established

1. Tetralogy of Fallot
2. Pulmonary stenosis with interauricular communication
3. Pseudotruncus arteriosus
4. Tricuspid atresia or stenosis
5. Single ventricle with pulmonary stenosis
6. Arteriovenous pulmonary aneurysm

##### GROUP II. Value of Operation Debatable

1. Pulmonary stenosis with interventricular septal defect
2. Complete transposition of the great vessels

#### *Coarctation of the Aorta*

**RULE No. 1.** The easiest way to diagnose coarctation of the aorta is to palpate the femoral arteries for diminished or absent pulsations followed by the recording of blood pressures in the extremities. The pressure in the upper extremities is always higher than in the lower ones.

In the vast majority of all patients the coarctation is located distal to the origin of the left subclavian artery. The heart is usually normal. Children are usually free from any symptoms. Make up your mind to palpate the femoral arteries on every patient that you examine. If you find that the femoral pulsations are absent or diminished, then record the blood pressure in the upper and lower extremities. Normally, as you know, the blood pressure in the lower extremities is higher than in the upper extremities by 10-20-30 or 40 mm. of Hg. In patients with coarctation of the aorta, the blood pressure in the lower extremities is less than that of the upper extremities. This

*continued on next page*

\*Presented at the 143d Annual Meeting of the Rhode Island Medical Society, at Providence, Rhode Island, May 6, 1954.

finding alone will establish the diagnosis in almost every case.

Usually there is hypertension in the upper extremities. I have seen pressures as high as 200 mm. of Hg. even in infants with coarctation of the aorta. However, if there are associated lesions such as subaortic or aortic stenosis, there need not be any hypertension in the upper extremities.

Record the pressures in both arms, because occasionally you may find a considerably lower pressure in the right arm than in the left arm and this will establish the additional diagnosis of a stenosis involving also the left subclavian artery.

There is nothing pathognomonic about murmurs in coarctation of the aorta.

The roentgen ray of the heart may reveal either a normal heart or left ventricular hypertrophy or, if there is heart failure, combined ventricular hypertrophy.

Notching of the lower portion of the mid-ribs is pathognomonic but usually does not appear until 6 to 8 years of age or later. If the left subclavian artery is also stenotic or arises below the coarctation, only the ribs on the right side will reveal notching.

Angiocardiology, in the left anterior oblique and retrograde aortography will usually reveal the coarctation. However, these procedures are not necessary to establish the diagnosis.

Catheterization is contraindicated because the catheter cannot enter the left side of the heart.

#### *Patent Ductus Arteriosus*

**RULE No. II.** A clinical diagnosis of a patent ductus arteriosus in a noncyanotic patient over 2 years of age should not be made *unless* there is a continuous machinery-like systolic and diastolic murmur over the pulmonary area.

**Exception:** In infants with very large shunts through the ductus, there may be only a systolic murmur. In these cases, a high pulse pressure is of great significance.

Strictly speaking, patent ductus arteriosus is not a congenital malformation of the heart but a persistence of the patency of the ductus as it exists in the foetus.

In the vast majority of all infants and children, there is usually no symptomatology. They get along very well. It is the characteristic systolic and diastolic murmur heard best over the pulmonary area that establishes the diagnosis. The murmur is usually continuous throughout systole with an accentuation at the end of it and throughout diastole. However, the murmur does not have to be continuous. It may occupy only a portion of systole with an accentuation at the end of systole and be followed by a high pitched diastolic murmur that may not occupy the whole of diastole.

The blood pressure usually reveals a high pulse pressure but may, in some cases, be within normal limits.

The roentgen ray may reveal a normal heart, or a convexity over the pulmonary area with left ventricular hypertrophy.

A hilar dance may or may not be present.

The electrocardiogram shows either a normal heart or a left ventricular hypertrophy.

Angiocardiology often times reveals early blanching of the pulmonary artery because of the shunt of the non-dye containing blood from the aorta into the pulmonary artery and on later films with the opacification of the left side of the heart, the pulmonary artery becomes reopacified.

Catheterization reveals a greater oxygen saturation of the blood samples obtained from the pulmonary artery than that of the right ventricle. The magnitude of the shunt can thus be figured out.

Retrograde aortography may show simultaneous opacification of the aorta and pulmonary artery.

Neither angiocardiology, retrograde aortography or catheterization are necessary to establish the diagnosis in the overwhelming majority of all patients.

During the past two to three years several reports appeared in the literature describing what may be called a "malignant type" of patent ductus arteriosus in infants. We have had experience with fifteen of these infants. These patients present an entirely different clinical picture. They are dyspneic, there may be rales in the lungs and enlarged liver because of heart failure and there may be only a systolic murmur. About half of our infants did have a systolic and diastolic murmur but this murmur may only be detected if the infants are sedated and even then it may be difficult to make out because of the marked tachycardia.

The roentgen ray in those infants reveals a very marked cardiac enlargement with marked hilar dance and combined hypertrophy with predominance of the left ventricle.

The electrocardiogram reveals either left ventricular hypertrophy or combined hypertrophy.

In the absence of a continuous murmur, the most important single clinical finding is the high pulse pressure that we have observed in all of our infants. This is due to the presence of a very large shunt.

While the optimum age for operation in the average patient with a patent ductus arteriosus is between three and four and ten years of age, these infants should be operated as soon as possible. Of our fifteen infants, four infants who were treated medically all died and the eleven infants who were operated there was no mortality.

There is still another type of patent ductus arteriosus which is fortunately rather rare, and

that is a patent ductus arteriosus with a reversal of the blood flow from the pulmonary artery into the descending aorta. In these patients the pressure in the right ventricle and pulmonary artery is higher than in the aorta. There is cyanosis of the lower extremities and the oxygen saturation of the femoral arteries is less than that of the radial arteries, especially that of the right side. Here an operation is usually contraindicated.

#### *Double Aortic Arch*

**RULE No. III.** A noncyanotic patient who has a history of repeated respiratory infections, wheezing, respiratory stridor or dysphagia should have a barium oesophagram. This may reveal a double aortic arch, or some other constricting vascular anomaly of the aortic arch.

In double aortic arch the anterior one is usually the smaller one. The oesophagus and trachea are in between the two arches. If this is present the above symptomatology, an operation consisting of sectioning the smaller arch is life saving.

In the posterior-anterior view, the oesophagus may be compressed bilaterally, but the oblique view reveals an anterior displacement of the oesophagus by the posterior arch.

#### *Isolated Pulmonary Stenosis*

**RULE No. IV.** A normal, noncyanotic or occasionally a cyanotic patient who has a loud, rough systolic murmur, diminished second pulmonic sound, a convexity over the pulmonary area, and a right ventricular hypertrophy may be a candidate for a valvulotomy.

This entity is not as rare as it was thought to be until five to ten years ago. Since we began recognizing this entity early in 1948, we studied about fifty patients at the Cook County Children's, the Presbyterian and the Research Hospital of the University of Illinois.

The outstanding findings in isolated pulmonary stenosis include the following:

Dyspnea may or may not be present and is directly proportional to the severity of the stenosis.

Loud systolic murmur over pulmonary area which may be widely transmitted. The second pulmonic sound is usually diminished or absent.

Fluoroscopy and roentgen ray examination usually reveal a straight or convex pulmonary area. The cardiac chambers may not show definite enlargement so that at times the heart may appear of normal size, or there may be an enlargement of the right auricle and the right ventricle.

Electrocardiogram reveals right ventricular and/or auricular hypertrophy.

Angiocardiogram in the right oblique view reveals a poststenotic dilatation of the pulmonary artery with delayed emptying of the artery.

Catheterization reveals high pressure in the right

ventricle and low pressure in the pulmonary artery. The peripheral arterial oxygen saturation is normal.

#### *Pulmonary Stenosis with Interauricular Communication*

**RULE No. V.** A cyanotic patient, whose roentgen rays and fluoroscopic findings reveal a heart that is usually not markedly enlarged and diminished vascular pulmonary pulsations, is most probably a candidate for surgery.

Exception: Patients with very marked isolated pulmonary stenosis usually show progressive and marked cardiac enlargement with a poststenotic dilatation of the pulmonary artery. These patients should have a pulmonary valvulotomy.

Outstanding findings in Pulmonary Stenosis with Interauricular Communication are:

A. If pulmonary stenosis is of moderate or mild degree: findings may be the same as in Isolated Pulmonary Stenosis, but mild dyspnea and cyanosis may be present. There may be in addition, a diminished peripheral arterial oxygen saturation.

Catheter may enter the left auricle from the right auricle.

Although the shunt is usually from right to left, the shunt may occasionally be from the left auricle to the right auricle even in the presence of high pressure in the right ventricle.

B. If pulmonary stenosis is of severe degree: early appearance of cyanosis and dyspnea.

Early and marked enlargement of the right auricle and of the right ventricle which, if not operated on, goes on to right heart failure.

Angiocardiogram may reveal simultaneous opacification of both auricles best seen in the left anterior oblique view followed by opacification of both ventricles and great vessels.

**RULE No. VI.** If patient is cyanotic and the cyanosis is due to congenital malformations of the heart, and if a roentgenographic or fluoroscopic examination shows that the heart is not greatly enlarged but is either normal or slightly enlarged, and if the vascular pulmonary pulsations are diminished—then that patient in almost every instance is operable. This is so because such a patient has one of the following conditions: 1) A tetralogy of Fallot, 2) A single ventricle with pulmonary stenosis, 3) A tricuspid atresia or 4) Pseudotruncus arteriosus.

**MONDAY, JANUARY 3**

**Annual Meeting of the**

**PROVIDENCE MEDICAL ASSOCIATION**

## THE DIAGNOSIS OF BRAIN TUMORS\*

ELDRIDGE CAMPBELL, M.D.

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### Introduction

THERE CAN, in my opinion, be little doubt that the problems in diagnosis which confront the general practitioner are more difficult than those subsequently reaching the specialist. It is the family physician who encounters diseases in their earlier phases, often long before the crystallization of recognizable syndromes. His burden is frequently increased by a heavy load of patients, among whom are many functional red herrings. He is indeed a clever man who can quickly sort the wheat from the chaff, the really sick from the imagined sick. Yet it is also a fact that the responsibility for getting the patient treated in time rests largely with this busy fellow. It is he who must at least *suspect* the correct diagnosis before irreversible damage has been done. It is the arousal of this suspicion regarding the presence of brain tumors which I should like to discuss this afternoon.

Brain tumors make themselves manifest in three principal ways: by increasing the intracranial pressure, by irritation and/or paralysis of adjacent neural elements, and in certain instances, by clinically recognizable endocrine disturbances.

*Increased intracranial pressure* is usually associated with headache, with spells of dizziness and eventually with nausea and vomiting. Pain which is mounting in severity, which is made worse by coughing or straining or bending over, and even more significantly that which may awake the patient from a sound sleep, should immediately arouse our suspicions. Dizziness may be experienced as a simple feeling of imbalance or impending blackout, as in the transient vasomotor inadequacies, or may take the rotational form of the true vestibular vertigo. One word about vomiting: it need not—despite what some texts imply—be projectile in type, and it may or may not be preceded by nausea.

\*From the Department of Surgery, Albany Medical College. Presented at the Seventh Annual Cancer Conference for Physicians, under the auspices of the Rhode Island Medical Society, at Providence, Rhode Island, October 13, 1954.

In children the vomiting often occurs in the morning and is all too often attributed to some gastrointestinal disorder.

*Alterations in the state of consciousness* appear as late manifestations of elevated intracranial pressure. The spectrum of drowsiness, stupor and eventual coma is known to all, but the intervening bands of restlessness, irritability and irrationality are all too frequently misinterpreted. Restlessness, particularly when alternating with periods of drowsiness, often is an omen of breaking compensation. Yawning, sighing and a curious tendency to rub the nose may be observed. By this time the last act in the drama has been reached; if the intracranial (not the intraspinal) pressure changes are not rectified at once, death will close the scene.

*Eyeground changes* occur early or late or not at all, depending upon the location and rate of growth of the tumor. Choking of one or both disks may be produced early if the tumor is growing rapidly. If an optic nerve be compressed by the tumor, the disk on that side will almost always become atrophic rather than swollen. As a general rule, changes in the optic fundus are missed not because they are difficult to see, but because they are not looked for. In most instances optic neuritis may be differentiated by its more diffuse oedema of the retina and particularly by the disproportionately large scotoma and loss of visual acuity. Malignant hypertension is distinguished by the arterial changes as well as the type of haemorrhages usually observed.

*Alterations of cardiorespiratory function* usually appear late. Slowing of pulse and respiration or such variations in the cycle as those referred to as Cheyne-Stokes are usually seen after changes in the state of consciousness have taken place. A pulse rate below fifty is highly significant, although the percentage fall the individual's norm is even more so. It is to be recalled that some people, particularly athletic young men, may have a rather slow pulse rate when in the best of health. I have known several whose resting pulse rate was around fifty. If elevation of blood pressure appears, it is usually near the end. The completion of a diagnosis should never be deferred pending the appearance of cardiorespiratory disturbances.

*Neurological changes* are brought about by in-

vasion or by compression; these in turn may take the form of irritation or of palsies. Convulsive seizures, trigeminal nerve pain and Meniere-like symptoms are examples of the former, while motor and sensory limb weaknesses are common examples of the latter.

Tumors which involve the cerebral hemispheres may bring about convulsions of any type. While Jacksonian epilepsy is the most dramatic of these manifestations and of great localizing value, it is to be remembered that any variety of fit may be an early symptom. In the more benign, slowly growing tumors, such as the meningiomas and astrocytomas, convulsions may be the only manifestations for as long as ten or fifteen years. Any patient who develops epilepsy after the age of thirty should be suspected of harboring a supratentorial neoplasm or vascular abnormality until proved otherwise.

*Visual disturbances* may bring the patient early to his personal physician or to his ophthalmologist. The danger here is that attention may be focused on the eye when the real trouble lies behind. When it is recalled that the visual apparatus extends through the optic chiasm, to the midbrain and through the temporal to the occipital lobes, its vulnerability to injury in many locations is readily understandable. These abnormalities take the form of blurring or loss of vision with local pressure on an optic nerve, or long standing papilloedema, diplopia and various tell-tale defects in the visual fields. The missing piece in many a diagnostic jigsaw puzzle is to be found by examination of the visual apparatus.

The value of visual field examination is illustrated by the following cases:

J.F., a thirty-three-year-old woman, presented herself with a history of generalized convulsions of eleven years' duration. The neurological examination was entirely normal save for left homonymous hemianopsia. Angiography gave indication of a mass in the right temporal lobe. At operation an enormous aneurysm was successfully removed from this otherwise relatively silent area.

Another recent illustration of the necessity of performing this examination was the case of a thirteen-year-old boy who sought relief of intermittent headaches of a few months' duration. While no neurological changes were evident and even the eye grounds appeared normal, gross testing of the visual fields with the finger revealed a bitemporal hemianopsia. Subsequent x-rays revealed a greatly enlarged sella turcica. At operation a benign pituitary adenoma was found and removed.

*Unilateral deafness* may long precede any other symptoms in a particularly benign tumor known as the acoustic neuroma. The onset may be so insidious that the patient only discovers it after all hearing has gone. Since the vestibular portion of

the eighth nerve is usually destroyed even before the auditory, a caloric or Barany test will reveal a dead labyrinth. A few of these patients experience aural vertigo quite similar to Meniere's disease, but unlike the latter they have an absent caloric response, an elevated spinal fluid protein and often some erosion about the porous acousticus demonstrable by roentgenogram. As the tumor increases in size the seventh nerve becomes stretched and thinned; curiously enough the trigeminal nerve, although situated further away, often fails before the facial. Homolateral pain above the brow and diminution of corneal sensitivity are usually the earliest manifestations of this nerve's compression. Tic douloureux-like pain may be precipitated, as in the case of cholesteatomas in the cerebellopontine angle. Involvement of the pontine medullary structure appears still later, as does increased intracranial pressure.

Finally, I should like to touch briefly upon another group of tumors, a most distressing group, since they are so often encountered in children, namely the cerebellar gliomas. Many of these are curable, particularly if operated upon early. Unexplained recurrent vomiting or disturbances of coordination of limb movements or gait in a child should make one consider this possibility. These symptoms sometimes precede headache, ataxia, choked disks or diplopia by several months. The earlier the diagnosis can be established the better the prospect for help; a ventriculogram usually affords a prompt answer.

*Roentgenography* will disclose the significant abnormalities in perhaps ten to twenty per cent of tumors. These changes are visible in the form of calcification within a tumor, bony erosion or bone formation adjacent to a tumor, abnormal vascular patterns, or displacement of a calcified pineal or choroid plexus. In infants and children separation of the sutures or a "beaten silver" type of thinning of the calvarium is often demonstrable.

In the majority of cases however, one must resort to the use of ventriculography or angiography to secure a positive diagnosis. Each method has its indications, its advantages and its disadvantages, of which time does not permit discussion today.

*Lumbar puncture* will tell you whether or not the protein and the pressure within the cerebrospinal fluid are elevated, but not whether this change, if present, is caused by a tumor. If normal, a tumor may yet be present. Since the procedure carries a definite risk I rarely have it performed on my patients, save when looking for blood or signs of infection. When patients are ill, it is particularly desirable to limit diagnostic procedures to those believed really essential to diagnosis.

In conclusion, I should like to remind you that tumors of the brain are not rare nor are they generally obscure. In most instances if one sits down

*concluded on page 674*

## MITRAL VALVULOPLASTY

## A Brief Review and Report of Thirty-one Patients Studied at the Rhode Island Hospital

FRANK MERLINO, M.D., FRANK B. CUTTS, M.D., and  
CLIFTON B. LEECH, M.D.

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ANY DISCUSSION of mitral disease necessitates consideration of rheumatic fever, at least as regards its aftermaths. This paper was primarily planned as a partial summary of a relatively new and dramatic phase of medicine; namely cardiac surgery, specifically surgery for mitral stenosis.

Many detailed studies concerning rheumatic fever and its sequelae have appeared in the literature. Among such studies is the twenty-year follow-up of 1000 children with rheumatic fever by Bland and Jones.<sup>1</sup> These observers found that after the initial illness, 653 children had signs of rheumatic heart disease which later disappeared in 16%. The remaining 347 children had no signs of heart disease initially but evidence of cardiac involvement appeared later in some 44%. 202 patients died in the first 10 years and a total of 301 were dead in 20 years. Of the 699 survivors only 25% had any limitation of activity.

From the above it is clear that rheumatic fever is not always followed by valvular heart disease. In fact, only a minority of those with unequivocal heart disease have symptoms of sufficient severity to limit their normal activity. It is this minority in which we are particularly interested in this discussion.

In 1883, Billroth<sup>2,3\*</sup> said, "Let no man who hopes to retain the respect of his medical brethren dare to operate on the human heart." Just how much such an opinion expressed by one of the most influential medical thinkers of his day served to deter progress along such lines is problematical. In any event, thought on the subject did not stop and in 1898 Samways<sup>4</sup> suggested that some of the severest cases of mitral stenosis might be relieved by slightly notching the mitral orifice. Sir Thomas Lauder Brunton<sup>5</sup> in 1902 again proposed the possibility of surgical correction of mitral stenosis and was roundly and roughly criticized by his contemporaries.

He did, however, stimulate further experimental animal work done by such men as Klebs,<sup>6</sup> MacCallum and McClure,<sup>7</sup> Cushing and Branch,<sup>8</sup> and Bernheim.<sup>9</sup>

Doyen<sup>10</sup> is credited with making the first attempt at surgery on the human heart. In 1913, he tried to correct a congenital pulmonic stenosis but encountered several other anomalies and his patient died. The following year, Tuffier<sup>11</sup> operated on a young man with isolated aortic stenosis. Although he originally planned to incise the valve, he instead did a simple invagination of the aortic wall with dilatation of the aortic orifice. His patient was doing well 10 years later. In 1923, Cutler and Levine<sup>12</sup> reported the first operation for mitral stenosis. Their patient was a twelve-year-old girl who was markedly limited by her disease. She lived four and one-half years but was benefited only slightly. The diseased valve was approached via the left ventricle and a portion of a leaflet excised, producing mitral regurgitation. Between 1923-1928, Cutler<sup>13</sup> operated on six other patients. None of these survived so he abandoned any further attempts at cardiac surgery. The first successful dilatation of the mitral valve was done by Souttar<sup>14</sup> in 1925. His patient was partially helped, but developed significant regurgitation. Thus, in the 1920's the prohibitive mortality discouraged further attempts at intracardiac surgery until after World War II. Then, the valuable experience gained in handling cardiac wounds during the war, the increasingly favorable results of surgical correction of congenital defects, the development of cardiac catheterization and greatly improved anesthetic techniques stimulated renewed interest in this field.

Efforts were initially directed toward reducing pulmonary vascular pressure. Several observers had noted the apparent protection of the lungs in patients with mitral stenosis who also had an interauricular septal defect — or Lutembacher's syndrome. Thus the production of such a defect was suggested. In 1948, Harken<sup>15</sup> performed such a procedure.

Because of the markedly dilated bronchial veins seen with mitral stenosis and the symptomatic relief at times obtained after hemoptysis, Bland and Sweet<sup>16,17</sup> in 1946 used a shunting procedure to

relieve the increased pulmonary pressure. In the years between 1946-1949, they performed twelve operations in which they anastomosed a branch of the right inferior pulmonary vein and the azygos vein and demonstrated a fall in left auricular pressure and relief of symptoms. This operation is recognized as a purely palliative one for strong, small hearts and mainly serves to protect the lungs. In reality, Harken et al<sup>18</sup> showed that the anastomosis soon became occluded.

After 1928, it was not until the late 1940's that the mitral valve was attacked again directly. In those years Bailey<sup>19</sup> and Harken<sup>15,20</sup> and his group operated on stenosed valves. Thus was born, a new era.

Anatomically, the normal mitral valve displays many variations.<sup>18</sup> In general it is best pictured as a continuous veil divided into leaflets by clefts. There are four such leaflets named the aortic, ventricular, posterior commissural and the anterior commissural. This arrangement is found in approximately 75% of normal hearts. The stenotic mitral valve, on the other hand, is divided by Harken<sup>18</sup> into two types. The first is characterized by a rigid, fibrous contraction of the leaflets to a stenotic opening with little thickening or fusion of the chordae tendinae. In about 85% of patients this picture will be seen. Type II stenosis consists of an elastic funnel with marked fusion of the chordae tendinae which may be of sufficient degree to cause a secondary stenosis. Calcification is common in type I but quite rare in type II. Many minor variations of these basic patterns are found. Type I appears to be more amenable to surgery and the postoperative results are apparently better in this group.

Patients may be fitted into one of four clinical groups dependent upon the degree of functional limitation. Group I includes those individuals with the auscultatory signs of mitral stenosis but with few if any symptoms and minimal evidence of increased pulmonary vascular pressure. These patients may pursue an entirely benign course. To return to the work of Bland and Jones<sup>1</sup> very briefly, only 117 of the 1000 rheumatic fever patients studied by them for twenty years developed pure mitral stenosis and only twelve of these developed evidence of serious pulmonary hypertension. Thus we can see that many will fall into this benign group. Their condition is not necessarily static, however, and progression to one of the more serious states not uncommonly occurs. In Group II one finds those patients who are somewhat handicapped by a fixed degree of moderate dyspnea on effort or by rare attacks of acute dyspnea or other pulmonary symptoms provoked by exertion, fatigue, or infection. Rarely will these people have mild edema but frank right-sided failure is not found. Group III patients demonstrate a progres-

sive disability. They show increasing dyspnea on effort or easily provoked attacks of hemoptysis, chest pain or pulmonary edema. Palpitation, tachycardia, and upper abdominal distress may or may not be present. The outlook in this situation is hazardous and these individuals may slip into Group IV or die in pulmonary edema or from emboli at anytime, for many have auricular fibrillation. The completely incapacitated compose Group IV. These are actually terminal cases. They are usually in chronic right-sided failure, manifested by increased venous pressure, hepatomegaly, and a marked tendency to congestion. Most are chronic fibrillators and often have a history of embolic episodes. Often there is evidence of poor liver function, even ascites, and diminished peripheral blood flow. The above is basically the classification employed by Harken<sup>18</sup> although of late he has started to utilize subdivisions of these main groupings. O'Neill et al<sup>21</sup> use a method of classification which is essentially the same except in that they reserve a separate division, termed Group V, for those who are not benefited, and indeed, are sometimes made worse by surgical intervention.

Since we know that most people with a stenotic mitral valve are not significantly incapacitated, it is obvious that not all will require surgery. No patients in Group I and probably few, if any, in Group II should be subjected to cardiac surgery. Ideally one attempts to determine that point in the progress of the affliction when symptoms are no longer static but are surely increasing to produce important disability. Such a decision is often not easy and is determined only by careful observation at relatively frequent intervals. Occasionally, one finds it very difficult to decide how much of the patient's symptomatology is due to mitral stenosis and how much is due to emotional problems. Especially is this true in younger women who complain of palpitation, dyspnea, chest pain, easy fatigue, etc., and have the physical signs of mitral stenosis but little else. In these instances laboratory tools including electrocardiograms, fluoroscopy, X-ray, exercise tolerance tests, and the like, are of invaluable aid.

Briefly, the ideal patient for mitral valvuloplasty is one who shows increasing disability, is under fifty, has pure mitral stenosis, a normal sinus rhythm, and a normal-sized heart.

The contraindications to this type of surgery are likewise somewhat difficult to define. There are, however, a few definite and absolute contraindications. These include active rheumatic fever, untreated subacute bacterial endocarditis, and an associated marked mitral regurgitation with a giant left auricle and enlarged left ventricle. Formerly, aortic stenosis was also considered a definite contraindication. Of late, however, it has been

*continued on next page*

learned that in such cases both valves may be operated upon through the same incision. In fact, the evidence appears convincing that the results in such double valve procedures may be better than for isolated aortic stenosis. Aortic regurgitation, if mild, and unaccompanied by peripheral signs, is not a contraindication to mitral valvuloplasty.

Auricular fibrillation, extensive calcification in the mitral valve, advanced age, tricuspid stenosis, and associated disease entities such as hypertension, arteriosclerosis, asthma, etc., of course present additional hazards.

In general, the purpose of mitral commissurotomy or valvuloplasty is threefold.<sup>22</sup> First, to enlarge the constricted orifice; second, to restore motion to the valve leaflets; third, to prevent future arterial emboli by eliminating the source of the thrombus and by reducing stasis in the left auricle.

It is not our purpose to discuss the actual surgical technique of mitral valvuloplasty except for a few brief comments. The auricular approach is now universally employed. A purse string suture is placed about the base of the left auricular appendage which is excised. Then the finger is inserted into the auricle and the valve explored. Some surgeons, including Harken, flush out the auricle before inserting the finger as one means of preventing emboli. Harken attempts first to separate the commissures by simple finger fracture. Bailey, on the other hand, uses a valvulotome routinely.

There are several important hazards for which the operative team must be on the alert. In addition to the dangers of hemorrhage and shock, arrhythmias are not uncommon and may require immediate treatment. For this reason, electrocardiograms are taken with a direct writer machine during the procedure. These disturbances in rate and rhythm seem most prone to occur during intubation, rib spreading, cardiac manipulation and the actual valve splitting. They include sinus tachycardia, auricular fibrillation and flutter, ventricular ectopic beats, and ventricular tachycardia and fibrillation. The supraventricular tachycardias are best treated by intravenous prostigmine, providing the patient has been fully digitalized, while pronestyl has been most successful in controlling the ventricular arrhythmias. Blood and norepinephrine are used for control of shock.

Numerous reports can be found in the literature attesting to the frequency of mural thrombi and embolic phenomena in patients with mitral stenosis and auricular fibrillation.<sup>23</sup> The danger of emboli during surgery is great and grave. This risk has been somewhat lessened by the isolation and occlusion of the head vessels during the brief time when the valvulotomy is done.

Postoperative care is not very different from that of most major thoracic cases. There are, how-

ever, a few important special points to remember. During the first few years of this surgery, it was felt that these patients needed at least 3000 cc. of fluid daily. On such a regimen, pulmonary edema and other signs of decompensation were quite common. More recently it has been the practice to limit the total fluid intake, oral and intravenous, to 1500 cc., excluding blood used for replacement, for about 72 hours or until a spontaneous diuresis takes place. On this regimen, the pulmonary and metabolic complications have become much less serious problems.

All patients develop pain at the site of incision and many show a widespread pericardial friction rub. The amount of pleural effusion on the operated side varies greatly but with the scheme of restricted fluids, as outlined, thoracentesis is rarely necessary. A large catheter on underwater seal is left in the pleural cavity and removed when the lung has completely expanded. On antibiotic therapy, post-operative fever is usually gone by the fifth day. Patients are allowed to dangle within two to three days and to get out of bed in four to six days.

As yet, it is much too early to calculate the "final" results, but preliminary reports are encouraging.<sup>24, 25, 26, 27</sup> The overall mortality appears to be around 6%, but in the sicker Group III patients and in the Group IV's, this figure rises to 20-25%. Harken<sup>28</sup> has ventured the opinion that all patients in whom an adequate valvuloplasty can be done will be somewhat benefited. Janton, et al<sup>27</sup> felt that 78% of their first 400 cases were improved. As already mentioned, the danger of emboli is a grave one, especially during the operative procedure. "Late" emboli, after operation, on the other hand, are relatively rare. Only three were encountered in Harken's first 500 cases.<sup>29</sup>

A peculiar clinical entity has been seen in an appreciable number of postvalvuloplasty patients. A similar picture is apparently not encountered in other cases undergoing thoracic surgery. This entity consists primarily of chest pain and fever of delayed onset. The former is usually of a pleuritic or pericardial type, being variably described as having from dull to knife-like intensity and being commonly aggravated by motion. The symptoms are of inconstant duration but usually last around ten days and may recur at irregular intervals for many months. The exact cause of this troublesome ailment is unknown. Some observers feel certain that it represents a mild flareup of rheumatic infection. This theory, however, is unproven. Soloff et al<sup>30</sup> reported the occurrence of this syndrome in 24.0% of 179 patients.

Since February, 1952, forty patients have undergone mitral valvuloplasty at the Rhode Island Hospital. Nine underwent operation too recently for evaluation and have not been included in this study. Follow-up studies included careful history and

physical examination, fluoroscopy of the chest, vital capacity determinations, exercise tolerance tests, unless contraindicated, and other studies when deemed necessary. Results have been classified as follows:

a) markedly improved; patients showing a definite increase in exercise tolerance and ability to carry on normal everyday activities;

b) moderately improved; patients showing some improvement in their ability to assume normal activities but in whom there is still some degree of limitation;

c) unimproved or made worse.

Patients ranged in age from nineteen to sixty-two years with the greatest number (fifteen) falling in the fourth decade. Seven others were in the fifth decade; four in the third; three in the sixth and one each in the second and seventh. This group included twenty-four females and seven males. Fourteen patients gave a definite history of a rheumatic infection and three others had a suggestive history. All but two patients had had congestive failure at some time. One of these two suffered at least two major embolic episodes. The other had repeated hemoptyses requiring transfusion on one occasion. In addition to this latter patient, thirteen others gave a history of hemoptysis of varying degree. With the aid of therapy with massive doses of antibiotics, one patient with probable subacute bacterial endocarditis, and not included in this series, was recently operated at the Rhode Island Hospital. Surgery was performed midway through the course of treatment. Harken<sup>31</sup> tells us he has done the procedure under similar circumstances in three instances.

Paradoxically, the auscultatory findings of mitral stenosis were changed little by surgery in the great majority. Whereas most showed a definite diminution in the intensity of the diastolic murmur during the early postoperative period, examinations made weeks or months later revealed murmurs of intensity almost equal to that noted preoperatively. Rarely, however, the less marked murmurs completely disappeared. In three patients significant degrees of mitral regurgitation were noted after operation. One of these had no systolic murmur prior to surgery.

Some observers feel that around 50% of postoperative valvuloplasty patients with auricular fibrillation can be reverted to a sinus rhythm with quinidine and be easily maintained. In this small series, there were nineteen chronic fibrillators. Of these, nine had had at least one embolic accident. Attempts at reversion were made in thirteen patients. In six, a normal mechanism was obtained but this could only be maintained in two patients with tolerable doses of quinidine. In fact, one of

these still has intermittent short paroxysms of fibrillation.

Patients were classified preoperatively according to the criteria listed by Harken and cited above. No Group I patients underwent surgery. The series included three Group II patients, twenty-one Group III patients and seven Group IV patients. There were two postoperative deaths. These included a fifty-two-year-old man in Group IV and recognized as an extremely poor surgical risk. Postoperatively he developed marked oliguria and increasing congestive failure in spite of therapy. The other death occurred in a twenty-seven-year-old woman who was considered a good candidate and was placed in Group II. About seventy-two hours postoperatively, however, she developed a resistant tachycardia with high fever and failure and rapidly went downhill. Necropsy revealed an acute pancarditis apparently from rheumatic fever.

The unimproved patients numbered two, one in Group III and one in Group IV. The former developed significant mitral insufficiency following operation and in the other pre-existing regurgitation was definitely aggravated. This latter patient is now leading an uncomfortable bed and chair existence.

Twenty patients in Group III, five in Group IV and two in Group II have been improved. Eleven of these appear to be completely unlimited in their activities while in sixteen there has been an increase in exercise tolerance but as yet they are unable to carry on all normal activities. Seven patients no longer require digitalis or diuretics and several others are taking digitalis only for control of the ventricular rate in the presence of auricular fibrillation. See Table I which summarizes these results.

Five of our patients developed symptomatology consistent with the "postoperative syndrome," with recurrent attacks in four. Therapy seemed to influence the illness little. Whether it was purely symptomatic including analgesics, bed rest, fluids, etc. or included antibiotics, episodes usually lasted some seven to ten days, abating slowly and progressively. Because of the suspicion of active rheumatic fever in one woman, a prolonged course of Cortisone was given with equivocal results.

Postoperative electrolyte imbalance presented a problem in thirteen patients. Treatment was usually

TABLE 1

	I	II	III	IV
Markedly improved (normal activity) .....	0	1	10	0
Moderately improved (some limitation remaining) .....	0	1	10	5
Unimproved .....	0	0	1	1
Dead .....	0	1	0	1

continued on next page

simple and included oral sodium chloride, ammonium chloride or potassium chloride as governed by the blood chemistries. On occasion physiologic saline was used intravenously and twice the calculated deficiencies were marked enough to require 5% saline solution. As experience accumulated, we learned that mildly to moderately depressed values for serum sodium in the early postoperative period corrected themselves without special therapy.<sup>32</sup>

All patients showed mitral stenosis at operation. As noted by other observers, late emboli were quite rare and in this group occurred only once. This was manifested by a transient, rapidly clearing hemiparesis several months after operation. Of interest too was the weight gain experienced by a majority of patients, reflecting improved nutrition.

Although we are well aware that the follow-up on patients undergoing mitral valvuloplasty will have to be much longer before final evaluations can be made, at the present time, it appears that the procedure has undoubted merit in selected patients.

The authors wish to express their gratitude to Doctors Dwight E. Harken and J. Murray Beardsley for their cooperation in the surgery and care of the patients herein reported.

#### BIBLIOGRAPHY

- <sup>1</sup>Bland, E.F. and Jones, T.D.: *Circ.* 4:836, 1951.  
<sup>2</sup>Billroth, T.: Quoted by Bland, E. F. (\*see reference

#### RHODE ISLAND MEDICAL JOURNAL

- No. 3) from Jeger, E.: *Die Chirurgie der Blutgefasse und des Herzens*, Berlin, A. Hirschwald. 1913. Page 295.  
<sup>3</sup>Bland, E. F.: *Circ.* 5:290, 1952. Excellent review of subject.  
<sup>4</sup>Samways, D. W.: *Lancet* 1:927, 1898.  
<sup>5</sup>Brunton, T. L.: *Lancet* 1:352, 1902.  
<sup>6</sup>Klebs, F.: *Prag. Med. Wechnsch.* 1:29, 1876.  
<sup>7</sup>MacCallum, W. G. and McClure, R. D.: *Bull. Johns Hopkins Hosp.* 17:260, 1906.  
<sup>8</sup>Cushing, H. and Branch, J. R. B.: *J. M. Research* 17:471, 1907-1908.  
<sup>9</sup>Bernheim, B. M.: *Bull. Johns Hopkins Hosp.* 20:107, 1909.  
<sup>10</sup>Doyen, E.: 26th Cong. de l'assoc. franc. de chir. *Presse med.* 21:860, 1913.  
<sup>11</sup>Tuffier, T.: *Tr. Internat. Cong. Med.* 1913. London, 1914; sect. 7, *Surg.* Part 2, p. 249, 1914.  
<sup>12</sup>Cutler, E. C. and Levine, S. A.: *Boston M. and S. J.* 188:1023, 1923.  
<sup>13</sup>Cutler, E. C. and Beck, C. S.: *Arch. Surg.* 18:403, 1929.  
<sup>14</sup>Souttar, H. S.: *Brit. M. J.* 2:603, 1925.  
<sup>15</sup>Harken, D. E.; Ellis, L. B.; Ware, P. F.; Norman, L. R.: *N.E.J.M.* 239:801, 1948.  
<sup>16</sup>Sweet, R. H.; Bland, E. F.: *Ann. Surg.* 130:384, 1949.  
<sup>17</sup>Bland, E. F.; Sweet, R. H.: *Tr. Am. Cl. & Climat. Assoc.* (1948) 60:71, 1949.  
<sup>18</sup>Harken, D. E.; Ellis, L. B.; Dexter, L.; Farrand, R. E. and Dickson, J. F.: *Circ.* 5:349, 1952.  
<sup>19</sup>Bailey, C. P.: *Dis. Chest* 15:377, 1949.  
<sup>20</sup>Ellis, L. B.; Harken, D. E.: *Tr. Am. Cl. and Climat. Assoc.* (1948) 60:59, 1949.  
<sup>21</sup>O'Neill, T. J. E.; Glover, R. P.; and Bailey, C. P.: *JAMA* 147:1032, 1951.  
<sup>22</sup>Janton, O. H.; Glover, R. P.; O'Neill, T. J. E.: *Circ.* 8:321, 1953.  
<sup>23</sup>Weiss, S.; and Davis, D.: *Am. H. J.* 9:45, 1933-34.  
<sup>24</sup>Glover, R. P.; O'Neill, T. J. E.; Harris, J. S. C.; Janton, O. H.: *J. Thoracic Surg.* 25:55, 1953.  
<sup>25</sup>Janton, O. H.; Glover, R. P.; and O'Neill, T. J. E.: *Am. J. Med.* 12:621, 1952.  
<sup>26</sup>Griffith, G. C.; Miller, H.; Cosby, R. S.; Levinson, D. C.; Dimitroff, S. P.; Zinn, W. J.; Oblath, R. W.; Herman, L. M.; Johns, V. J., Jr.; Meyer, B. W.; Jones, J. C.: *Circ.* 7:30, 1953.  
<sup>27</sup>Janton, O. H.; Glover, R. P.; O'Neill, T. J. E.: *Circ.* 8:321, 1953.  
<sup>28</sup>Harken, D. E.: Personal communication.  
<sup>29</sup>Preliminary report delivered by Ellis, L. B., before the January, 1954 meeting of the New England Cardiovascular Society.  
<sup>30</sup>Soloff, L. A.; Zatuchni, J.; Janton, O. H.; O'Neill, T. J. E. and Glover, R. P.: *Circ.* 8:481, 1953.  
<sup>31</sup>Harken, D. E.: Personal communication.  
<sup>32</sup>Dexter, L.; McDonald, L.; Rabinowitz, M.; Saxton, G. A., Jr.; Haynes, F. W.: *Circ.* 9:758, 1954.

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## Of Mistletoe and Holly

A SPRIG of mistletoe hung in a strategic spot is a regular part of Christmas decoration in many homes. The plant has become almost entirely a symbol of romance although many know of its use by the Druids and early Christians in religious ceremonies. The fact that it has a long and interesting medical history is not as well known.

Its use in medicine was described by Paulus Aegineta, Pliny, Celsus and Avicenna; it was widely used in the Middle Ages for nervous disorders. The early part of the twentieth century saw it being tried in the treatment of albuminuria, hemoptysis and as an oxytocic. Physicians in Germany are experimenting with an extract of viscum album in the use of cancer at the present time.

The lovely green holly with its gay red berries, which we use for Yuletide packages and mantel decorations, was once considered important in the therapy of intermittent fevers. The U. S. Dispensary devotes several columns to mistletoe and holly.

The current display in the exhibition case in the Reading Room at the Medical Library shows several items illustrative of medical aspects of these two favorite Christmas symbols.

*continued on next page*

## MEN, MAIDENS, AND MEDICINE

**W**E BELIEVE that it may be stated categorically that never in the 142 years of the Rhode Island Medical Society has the entire field of medicine been so thoroughly and beautifully covered as at the meeting at the Pawtucket Golf Club on October 27, 1954; and we wish especially to emphasize the beautiful aspect.

We had three handsome physicians for the purely scientific part of the program and they gave an unusually capable panel discussion of diseases of the thyroid gland. Dr. Bentley P. Colcock, of the Lahey Clinic, gave a careful discussion of "Tumors of the Thyroid." Dr. Earle M. Chapman, of the Massachusetts General Hospital and the Harvard Medical School, covered a wide field when he spoke about "Medical Phases of Hyperthyroidism," contrasting the use of the drugs and surgery with the very modern treatment with radioactive isotopes.

Dr. Oliver Cope, also of Harvard and the Massachusetts General Hospital, abandoned his scheduled intention of talking on the "Surgery of Hyperthyroidism," and instead gave a closely reasoned broad philosophical discussion of all the aspects of thyroid disease and surveyed in a general manner the contrasting treatments. He spoke particularly of what our moral attitude should be as we approach these problems, not any of which are, of course, entirely solved yet, if they ever will be.

These three men contributed an unusually good scientific program, but what really led us to the hyperbole of our opening remarks was the program presented by members of the Woman's Auxiliary in which they discussed the many parts of medicine. Mrs. Banice Feinberg, the president, showed wonderful courage as well as judgment when she brought on from California this remarkable presentation "There is a Doctor in the House."

Our ruling dynasty of middle-aged to elderly physicians have, through long and sad experience, developed skepticism, and we are sure when approached by Mrs. Feinberg with her scheme they shook their heads, but she assured them that among the wives of our members there was a super abundance of talent, pulchritude and agility requisite for a musical performance. These young ladies soon showed us that they were able to cover in an intelligent and properly discriminating manner the whole broad field of medicine. Never have we heard more enthusiasm expressed at a medical meeting. Our next-hand neighbor said to us when the finale was finished, "That ought to be on TV!" When we think of the showing of a gruesome gastrectomy to the general public by television, we consider that a very restrained statement.

By an interesting coincidence we have just seen

an account of an address made to the Massachusetts Medical Society about seventy-five years ago. The subject was the rights of women and whether they shall be doctors. The remarks were as follows:

Mr. Chairman, the excellent brain power and judgment, as well as the finer and better qualities of humanity which women can bring to any profession or calling, should not be lost to the world and to civilization.

Can anyone doubt that our doctors' wives, although not aiming to be physicians themselves, are justifying the confidence expressed in them by that farseeing judgment seventy-five years ago?

We thank our visiting Boston scientists and the ladies of the auxiliary for an instructive and delightful evening.

### CARDIAC SURGERY

Of all the advances in surgery in recent years, none has been so dramatic as the rapid development of cardiac surgery. As pointed out in an article in this issue, page 670, the concept of the surgical correction of mitral stenosis was actually advanced over one-half century ago. The factors which have made this procedure feasible now are the improvement in anesthesia—particularly the techniques of maintaining adequate oxygenation in the presence of an open hemithorax, the availability of antibiotics and chemo-therapeutic agents to minimize postoperative infections, and above all, the courage, initiative and ingenuity of able surgeons. For example, when Dr. Dwight E. Harken approached Dr. Elliott C. Cutler, the pioneer in the transventricular approach, about the possibility of cutting the mitral valve through an atrial approach, he was advised not to attempt it at all because of the marked friability of the atrial myocardium. Animal experimentation eventually showed that the auricular appendage afforded a practicable route and excellent results, such as those summarized in the paper referred to previously, attest to its success. As is so often the case in medicine, other workers, including Bailey and his group in Philadelphia, simultaneously and independently came to the same conclusion.

But it is not only in mitral valvulotomy that cardiac surgery has progressed. There are the various shunt operations perfected by Blalock and his associates for the correction of congenital lesions; the ligation of the patent ductus arteriosus; and the beginnings made in repair of septal defects. The use of arterial homografts is now making possible the correction of stenotic and obstructing lesions of the aorta. Even prosthetic valves have been successfully inserted to compensate for the

deformed natural ones, although it must be admitted that this type of cardiac surgery is still largely experimental. Mechanical heart-lung devices now in use in a few centers, may make repair of valvular and septal lesions feasible under direct vision.

Progress appears being made in another field of cardiac surgery, namely that of directly improving the blood supply of the myocardium, damaged by coronary insufficiency. Although many different vascularizing procedures have been advocated for this purpose, the failure of widespread acceptance of any one is indicative that a truly effective method has as yet not been found. Correction of valvular and congenital defects appears well on its way, but it is the problem of restoring myocardial circulation that provides the greatest present challenge to modern cardiac surgery.

### MANY BRAVE MEN FOUGHT BEFORE AGAMEMNON

As we mentioned the subject matter of this editorial to a savant (that word is French) whom we often consult concerning medical literature, he gave us the above quotation from "Horace."

The late Dr. Samuel Harvey, Professor of Surgery at Yale, frequently bewailed the fact that he could not interest his students in anything dating back more than ten years. The wisdom of John Hilton writing on "Rest and Pain" a century ago meant much less to the youngsters than the dose of the latest antibiotic. This lack of knowledge of the best things of the past is to be deprecated. Our great leaders—Osler and Cushing, for example—profited much by what went on before them.

The trigger mechanism that started us along this line of thought was the taking down from the shelves of a handsome leather-bound copy of Dewees' *SYSTEM OF MIDWIFERY*. This was published in 1837. We consulted another savant from the Providence Lying-In Hospital, where they flourish, and had our attention called to a letter written in September, 1824 from Dr. W. E. Horner, Professor of Anatomy at the University of Pennsylvania, to Dr. Dewees. We include a portion of the letter:

There has been a frequent subject of conversation with our common friend, Dr. Physick . . . if the distention of the bladder be much increased, the peritoneum even leaves the anterior face of the cervix uteri, and its reflexion to the bladder departs thence at the lower part of the body itself of the uterus. Dr. Physick . . . proposes that in the Caesarian operation a horizontal section be made of the parietes of the abdomen, just above the pubes. That the peritoneum be stripped from the upper fundus of the

bladder, by dissecting through the connecting cellular substance, which will bring the operation to that portion of the cervix uteri where the peritoneum passes to the bladder. The incision being continued through this portion of the uterus, will open its cavity with sufficient freedom for the extraction of the fetus. All of which the doctor supposes may be done by a careful operation, without cutting through the peritoneum. It is evident that if this be a practicable operation, it will diminish immensely the tendency to peritoneal inflammation. . . .

Thus you see that the modern method of doing a Caesarian section, which was proudly taken up by our hospital here some time after 1925, had been carefully described in a well-known book a century before. Of course in the days before anesthesia and asepsis the surgeons could not well do a careful operation. They had to slash horridly; nevertheless, here stood this well-described technique for many years after it was practical to use it.

Then we fell into a conversation with a young man practicing an up-to-date part of our profession—that is plastic surgery. He evidently is not above looking back for knowledge and wisdom that had been developed even before his entrance into medicine, and he told us of a book written by Gaspere Tagliacozzi of Bologna some four hundred years ago. This book describes very accurately the operative technique used in reconstructing a nose by the use of a pedicle, tubed flap from the inner aspect of the upper arm, going into detail as to the method of constructing the pedicle, the method of transplanting it to the nose, and the method of binding the arm to the head to hold the arm in position while the pedicle is attaching itself.

One of our bright young men some years ago devised a new stitch and wrote an article about it. It was an excellent stitch but through the centuries numerous men had invented it, each one attaching his own name to it.

There is more to any profession than the mere cataloging of some facts, but even that catalog may be added to by a scanning of the background as well as the foreground. A physician should be a wise man as well as a learned man, and we think that there is nothing that is more apt to produce this wisdom than a historical perspective.

### OF ETHICS AND DEPORTMENT

In recent years, influenced by newspaper and magazine writings, the public—including doctors—have been confounded with misunderstandings regarding the ethics of medicine. Such writings too often emphasize directly, or by inference, that every grievance of whatever nature that the individual may have against a physician is a matter of ethics warranting a full investigation of the doc-

*continued on next page*



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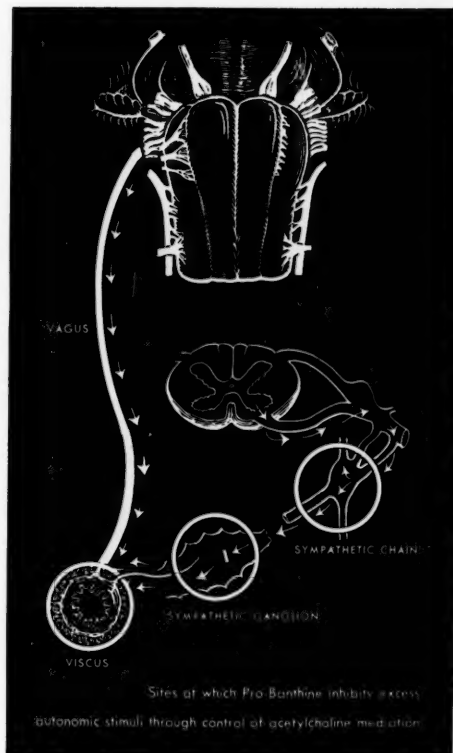
Roback and Beal<sup>2</sup> found that Pro-Banthine orally was an "inhibitor of spontaneous and histamine-stimulated gastric secretion" which "resulted in marked and prolonged inhibition of the motility of the stomach, jejunum, and colon. . . ."

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For the average patient one tablet of Pro-Banthine (15 mg.) with each meal and two tablets (30 mg.) at bedtime will be adequate. G. D. Searle & Co., Research in the Service of Medicine.



1. Schwartz I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: *Gastroenterology* 25:416 (Nov.) 1953.

2. Roback, R. A., and Beal, J. M.: *Gastroenterology* 25:24 (Sept.) 1953.

## ACCIDENTAL WART AUTO-INOCULATION

### Report of an Unusual Case

ARTHUR B. KERN, M.D.

The Author, *Arthur B. Kern, M.D., of Providence, Rhode Island. Dermatologist, Active Staff, Charles V. Chapin, Miriam, Rhode Island, Roger Williams General and St. Joseph's Hospitals, State Hospital for Mental Disease, and State Infirmary. Instructor in Dermatology, Boston University School of Medicine.*

ALTHOUGH one of the most common entities which the physician is called upon to treat, the wart has, nevertheless, long been an enigma. The superstitions and bizarre beliefs that have arisen concerning these tumors are innumerable and many persist to the present. Scientific knowledge about them, although accumulated slowly, has reached the point where the etiology of these growths is now established.

Kühneman,<sup>1</sup> in 1889, maintained that they were of bacterial origin. Variot,<sup>2</sup> in 1893, reported that inoculation of blood from small verrucae produced "positive results." Jadassohn,<sup>3</sup> in 1894 injected bits of wart tissue into the skin and of seventy-four inoculations thirty-one gave rise to the development of typical warts. In 1907, Ciuffo<sup>4</sup> was the first to show that the responsible organism was filtrable. Serra,<sup>5</sup> in 1908, confirmed Ciuffo's results. Wile and Kingery,<sup>6</sup> in 1919, reported on their success in producing warts in the skin of subjects inoculated with the filtrate of wart tissue which had been ground up with a small amount of normal saline and passed through a Berkefield filter. Further evidence for the viral etiology has been the demonstration of inclusion bodies. Strauss, Bunting and Melnick,<sup>7</sup> for example, in 1951 reported finding inclusion bodies and cytoplasmic masses in twenty-one or thirteen per cent of 156 common and plantar warts. Bivins<sup>8</sup> has recently reported on his results with inoculation of wart tissue on to the chorio-allantoic membrane of the chick embryo. He observed the presence of inoculation point cysts and many hard, whitish "pearls." A Berkefield filtrate prepared from ground suspension of a heavily infected membrane when inoculated on the chorio-allantoic membranes of chick embryos produced well-developed lesions, suggesting that the virus had been isolated.

The relationship between the various types of human warts has not yet been definitely established. However, it appears likely that verruca vulgaris,

verruca plana juvenalis, verruca plantaris and verruca acuminata are all due to the same or very closely related viruses, the clinical manifestations being determined by the location of the lesion.

As has been described, the infectious nature of warts has been adequately shown experimentally. On the basis of clinical evidence, however, we have only been able to assume their infectiousness from such observations as mother and daughter warts, development of verrucae on opposing surfaces and the presence of different types of warts in the same individual. The case to be described, which to the author's knowledge is the only one of its kind in the literature, clearly demonstrates the infectious nature of these lesions.

#### Report of a Case

C.B., a thirty-eight-year-old female, in July 1953 noted the development of a painful lesion of her toe. One month later, while paring this down, she accidentally cut her right index finger with the contaminated razor blade. The wound was superficial, but deep enough to cause bleeding. It healed uneventfully within ten days. About three weeks after the injury she observed the onset of thickening in the scar. This gradually increased in size, becoming raised and painful. Application of Whitfield's ointment had no effect other than to induce redness and scaling of the surrounding skin. Her past history was essentially negative except for the fact that fifteen years previously she had had warts on her hands and elbow which had been successfully removed by electrodesiccation.

The patient was first seen by the author in January 1954, five months after the injury to the finger. On the lateral aspect of the right second toe was a round, yellowish, elevated, slightly tender, verrucous lesion measuring 0.73 cm. in diameter; in its center were several black dots. On the ulnar side of the distal phalanx of the right index finger was a linear, slightly curved, elevated, yellowish, moderately tender mass with surrounding mild erythema and scaling. The lesion measured 1.27 cm. in length and 0.32 cm. in width (see figure). At one end were several characteristic black dots. According to the patient, the neoplasm corresponded exactly in its location to that of the original wound. Both lesions were typical warts.

## SUMMARY

1. The development of a wart as the result of accidental auto-inoculation is described.

2. This case clinically demonstrates the infectious nature of such lesions.

## REFERENCES

- <sup>1</sup>Kühneman, G.: Cited by Wile and Kingery.<sup>6</sup>
- <sup>2</sup>Variot, J.: Cited by Wile and Kingery.<sup>6</sup>
- <sup>3</sup>Jadassohn, J.: Cited by Wile and Kingery.<sup>6</sup>
- <sup>4</sup>Ciuffo, G.: Cited by Bivins.<sup>8</sup>
- <sup>5</sup>Serra, A.: Cited by Bivins.<sup>8</sup>
- <sup>6</sup>Wile, U. J., and Kingery, L. B.: The Etiology of Common Warts: Preliminary Report of an Experimental Study, J.A.M.A. 73:970 (Sept. 27) 1919.
- <sup>7</sup>Strauss, M. J., Bunting, H. and Melnick, J. L.: Eosinophilic Inclusion Bodies and Cytoplasmic Masses in Verrucae: Their Incidence in 156 Lesions Consecutively Removed, J. Invest. Dermat. 17:209 (Oct.) 1951.
- <sup>8</sup>Bivins, J. A.: The Growth in the Developing Chicken Embryo of a Filtrable Agent from Verruca Vulgaris, J. Invest. Dermat. 20:471 (June) 1953.



## LEGEND

Between the arrows is the wart which resulted from accidental auto-inoculation. Unfortunately, the black dots do not show too well. The surrounding erythema and scaling were due to application of medication.

## MAGAZINE SUBSCRIPTIONS

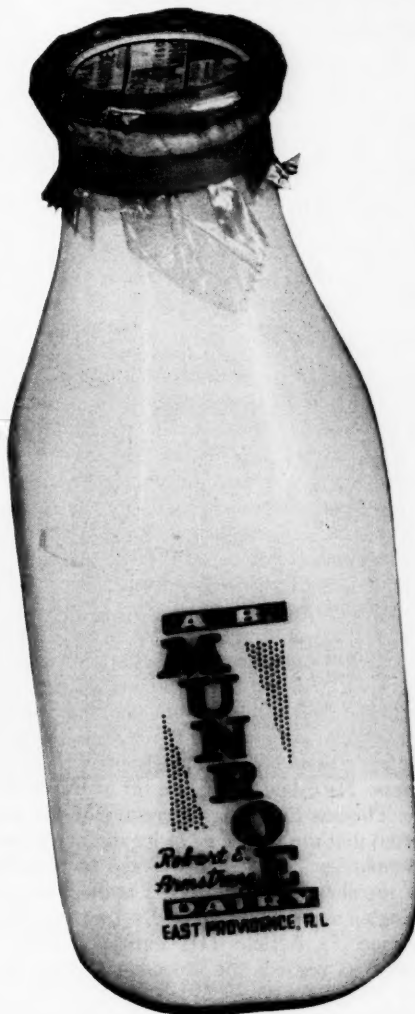
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## MEDICAL SOCIETY MEETINGS

### INTERIM MEETING of the

#### RHODE ISLAND MEDICAL SOCIETY

The 1954 Interim Meeting of the Rhode Island Medical Society was held at the Pawtucket Golf Club on Wednesday, October 27, 1954. Approximately 130 Fellows of the Society assembled for a scientific program at 4:00 P.M. on the subject of "Diseases of the Thyroid Gland."

The guest speakers were: Bentley P. Colcock, M.D., of Boston, Massachusetts; Member, Surgical Staff, Lahey Clinic, and the New England Deaconess and New England Baptist Hospitals, who spoke on "Tumors of the Thyroid"; Earle M. Chapman, M.D., of Boston, Massachusetts; Assistant Clinical Professor of Medicine, Harvard Medical School; Physician, Massachusetts General Hospital, who spoke on "Medical Phases of Hyperthyroidism"; and Oliver Cope, M.D., of Boston, Massachusetts; Associate Professor of Surgery, Harvard Medical School; Visiting Surgeons, Massachusetts General Hospital, who spoke on "Surgery of Hyperthyroidism."

Following the presentation by the panel there was a question and answer period with the panel and audience participating.

*Business Meeting.* At the conclusion of the scientific program Dr. Henri E. Gauthier, president of the society, declared the society to be assembled for a general meeting to transact any necessary business. He called for the report of the secretary.

Dr. Thomas Perry, Jr., secretary of the society, reported that the House of Delegates at its meeting on September 27, 1954 had voted to recommend to the membership of the society at the next general meeting an amendment to the By-Laws as follows:

Section 7, Article III, entitled "Dues," be amended as regards the second paragraph as follows:

"Fellows having attained the age of seventy (70) shall, if they so request, be exempt from payment of dues."

Dr Perry stated that the House of Delegates had taken this action to bring the regulations of the Society in line with those of the American Medical Association as regards exemption from the payment of dues because of age.

The president called to the attention of the Fellows that the amendment could be acted upon by a majority vote of the Fellows present and voting, and since the amendment had received the approval of the House of Delegates he called for action.

It was moved that the by-laws be amended as proposed. The motion was seconded and adopted.

There being no further business to be transacted the president adjourned the meeting.

After a reception and cocktail hour the Fellows of the Society and their wives attended dinner, after which members of the Woman's Auxiliary presented an entertaining sketch entitled, "There is a Doctor in the House."

Respectfully submitted,  
THOMAS PERRY, JR., M.D., *Secretary*

#### PAWTUCKET MEDICAL ASSOCIATION

A regular meeting of the Pawtucket Medical Association was held October 21, 1954 at the Lindsey Tavern. Forty members were present.

The minutes of the September meeting were read and accepted.

The applications of Dr. E. Klufas, O. Stapan and W. Roberts for active membership were approved on written ballots.

The application of Dr. C. Zawirski for active membership was read and referred to the Standing Committee.

Mr. Herbert Brooks, vice-president of the Memorial Hospital, presented his views on the manner in which investments should be made and managed. In effect he said that if we had faith in America and invested wisely our savings would rise in value in proportion to the growth of the country.

The question of Social Security for doctors was brought up for discussion and it soon became apparent that there were some sharp differences of opinion. After a time of rather animated discussion Dr. Riemer moved that the Pawtucket Medical Association go on record as in favor of the plan. Motion seconded by Dr. J. Doll. Dr. Charles Farrell proposed that the motion be amended to require a poll of the entire membership and that the decision be based on a majority vote. The amendment to the motion was seconded by Dr. Mathewson and carried on a voice vote. The amended motion was also passed on a voice vote.

Dr. J. Doll's motion that we send \$25 to the American Association of Physicians and Surgeons was seconded by Dr. Henry Turner and carried on a voice vote. The purpose of the donation is to support the Freedom Program of the American Association of Physicians and Surgeons.

The meeting was adjourned at 10:18 P.M.

Respectfully submitted,  
PHILIP J. LAPPIN, M.D., *Secretary*

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## BOOK REVIEWS

*TEXTBOOK OF PEDIATRICS.* Edited by Waldo E. Nelson, M.D. W. B. Saunders Company, Phil., 1954. 6th ed. \$15.00

The sixth edition of this excellent pediatric text, which has been one of the beacons of pediatric progress for many years, has kept pace with the preceding editions in revising out-of-date information and keeping up with the trends in medical thinking. This text has always been of great assistance to students and practitioners, particularly since the emergence of the fourth edition when the style was changed, and the improvements in the present volume make it "required reading." All the specific changes and additions are too numerous to mention, but some deserve comment such as the clear cut chapter on drug therapy, which has been structured with simplicity and accuracy, and widened in scope. The discussions of the metabolic disorders reflect the increased knowledge of cellular physiology and chemistry, and its application to clinical conditions. This is also evident in the chapters on disorders of the newborn and premature infants, fluid replacement therapy and endocrine disorders. Additional disease states have been included, such as Cat Scratch Fever, the Coxsackie Virus disorders and Sarcoidosis which increases the reference value. There has been marked improvement in the very important chapter of household poisons and the management of their accidental ingestion. One can feel quite sure of finding most of the common and some of the uncommon agents listed for ready reference.

The review of systemic disorders is presented essentially as before, but most of the work has been gone over to reflect more recent knowledge. This is particularly true of the section on congenital heart disease, where improved diagnostic measures and therapeutic considerations make the reader feel more familiar with this difficult, but formerly more inaccessible group of malformations. The section on infectious diseases has also been brought up to date with recommendations for the more recent drug therapy. The current knowledge of ACTH and Cortisone activity is revealed in many areas of this edition where newer methods of management of known disorders are discussed.

With all its added scientific data, the awareness of the child as a human being also is well brought

out by the excellent chapters on the emotional development and the untoward deviations which can occur. It is encouraging to see this aspect of pediatrics becoming more and more prominent. And finally the text is still partially prefaced by the advice of the author who cautions his readers lest they become specialists in the diseases of children, rather than specialists for children.

H. B. LANG, M.D.

*LETTERS TO A DOCTOR'S SECRETARY* by Anna Davis Hunt. Medical Economics, Rutherford, N.J., 1952.

This book, written by a woman who had been a surgeon's secretary for sixteen years, in the form of letters to her successor, is really a *complete* medical secretarial course covered in only 75 pages. The letters, first published individually in *MEDICAL ECONOMICS*, brought so many requests for reprints it was decided to publish them in book form.

The first chapters deal with items such as meeting the public, establishing good will, making the office a pleasant, seemingly unhurried place and in general making the patient feel at home. Mrs. Hunt tells what the secretary should wear and goes into detail on telephone technique.

She explains the ethical disposition of patients without appointments, visiting doctors, the doctor's family and friends, salesmen, etc. and the patient referred by another doctor.

Office correspondence, i.e., letters to referring doctors, insurance forms and requests for charitable contributions, are discussed.

The book contains an excellent chart of prefixes, roots and suffixes, to help the secretary learn medical terminology.

The routine of office hours, preparing the patient for examination and assisting at examination are discussed in detail.

Mrs. Hunt goes into the technical details on setting up and assisting at minor operations, aseptic technique, which instruments to boil or autoclave, the sterile tray, care of rubber gloves and how to prepare the specimen to be sent to the laboratory.

Setting up a case history record, bookkeeping system and billing are described and a large section

*continued on page 686*

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## BOOK REVIEWS

*continued from page 684*

is devoted to tactful methods of collections with sample letters.

A bibliography of publications to assist the doctor's secretary with almost any problem is included. The book concludes with a three-page quiz for the secretary.

This handbook would be of great value to the secretary unschooled in medical work and is an excellent refresher course for the trained medical secretary. One cannot think offhand of a problem which would arise in a busy office that is not covered in this manual.

AVIS K. BEARSE

*Secretary to Dr. Meyer Saklad*

**THE PRE-ADOLESCENT EXCEPTIONAL CHILD.** Proceedings of the 35th Conference of the Child Research Clinic of the Woods Schools. The Woods Schools, Langhorne, Pennsylvania.

This sixty-odd page pamphlet is apparently a verbatim report on the proceedings of the 35th Conference of the Child Research Clinic of The Woods Schools, held in Philadelphia, May 23, 1953.

While the term "exceptional child," used by the Woods Schools to embrace such divergent diagnoses as infantile schizophrenia and mental retardation strikes this writer as being unduly euphemistic and divorced of scientific reality, it is apparently here to stay as a sort of social sugar coating for psychiatric diagnoses of mental and emotional states whose prognosis is guarded and which are basically distressing to the parents of the unlucky child.

Of the many papers presented dealing with the various types and problems of pre-adolescent children, the most interesting was "Diagnosis of the Various Syndromes Encountered by the Retarded Pre-Adolescent Child," by Archie A. Silver, M.D., Senior Psychiatrist and Director of the Children's Section of Bellevue Hospital Mental Hygiene Clinic. The following quotation from Dr. Silver's summary of his paper typifies both its style and content and the conclusions he reaches.

"Schizophrenia is characterized by the retention of embryological characteristics in homeostasis, muscle tone, motility, respiratory patterns, and states of consciousness. Anxiety, ego-boundary problems, difficulty in object identification, and neurotic defenses are important symptoms resulting from this disturbance.

"The organic syndrome is characterized by abnormality in motor performance, in patterned and reflex behavior, perceptual deficits, and in the resulting emotional and social response. Lastly, the

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effects of emotional deprivation in infancy have been briefly mentioned." (p. 19)

The remaining principal papers titled "Treatment of the Mentally Retarded Pre-Adolescent Child" and "Treatment of the Emotionally-Disturbed Pre-Adolescent Child," by Gale H. Walker and Leon Eisenberg respectively, are rather lengthy and summarize the well-known difficulties encountered in the treatment of such patients. With the exception of Dr. Walker's mentioning of such adjuvants to treatment as B-12 and Testosterone in the treatment of mental retardation, and Dr. Eisenberg's cogent cautioning that "Enthusiasm for the unquestionably important discovery of the parental role has led to an over-emphasis of its significance," (p. 35) little information not already known to physicians even superficially in touch with these problems is presented. The six remaining papers comprising the afternoon panel discussion titled "What's Ahead? The Outlook in the Future for the Retarded Pre-Adolescent Child and His Parents" typifies an intrinsic weakness of panel discussions in which too many people are asked to talk too much about too little. Of the 40 publications of the Child Research Clinic listed at the back of the pamphlet, 30 are out of print, but available on loan. For the audistically minded, the proceedings of this and the previous conference in May 1952, "Helping Parents Understand the Exceptional Child" are available on 33 $\frac{1}{3}$  LP records.

The paper may be evaluated: tintillating to the psychiatric neophyte; too turgid and verbose for the average physician; and unproductively time consuming for the specialist.

WILLIAM L. MAURAN, M.D.

#### DOCTOR GAUTHIER FETED

On November 6, at the Winnesuket Country Club in South Bellingham, Massachusetts, the Woonsocket District Medical Society sponsored a testimonial dinner to Dr. Henri E. Gauthier, the second Woonsocket physician to head the Rhode Island Medical Society in more than two decades. In addition to a large representation from the district society, and its auxiliary, a delegation of the State medical society was present, including Dr. Charles L. Farrell, AMA delegate and president of the national Conference of Presidents and Other Officers of State Medical Association, who was one of the two speakers eulogizing Dr. Gauthier for his outstanding contributions to the progress of organized medicine in Rhode Island. Dr. Auray Fontaine spoke for the Woonsocket Hospital Staff Association, and Dr. Joseph B. McKenna, president of the Woonsocket District Society, and chairman of the testimonial, presented gifts of a clock to the guest of honor, and a radio to Mrs. Gauthier.

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## ON THE MEDICAL LIBRARY BOOKSHELVES

### *Recent Accessions*

The following books have been added to the Davenport Collection and are available for circulation:

Noah D. Fabricant, editor—*Why We Became Doctors*. Grune & Stratton, N.Y., 1954.

Noah D. Fabricant & Heinz Werner, editors—*The World's Best Doctor Stories*. Garden City, N.Y., 1951. Gift of Mrs. Garreau.

John Fleetwood—*History of Medicine in Ireland*. Dublin, 1951.

Donald Fleming—*William H. Welch and the Rise of Modern Medicine*. Edited by Oscar Handlin. Little, Brown and Company, Bost., 1954.

Andre Soubiran—*The Healing Oath*. Translated by Oliver Coburn. G. P. Putnam's Sons, N.Y., 1954.

S. O. Waife, editor—*The Doctor Writes. An Anthology of the Unusual in Current Medical Literature*. Grune & Stratton, N.Y., 1954.

*Several Day Fund purchases have been made:*  
Lauren V. Ackerman & Juan A. del Regato—*Cancer. Diagnosis, Treatment, and Prognosis*. 2nd ed. C. V. Mosby Company, St. L., 1954.

*Collected Papers of the Mayo Clinic and the Mayo Foundation*. Edited by Richard M. Hewitt & others. Vol. XLV, 1953. W. B. Saunders Company, Phil., 1954.

Arthur M. Fishberg—*Hypertension and Nephritis*. 5th ed. Lea & Febiger, Phil., 1954.

Arthur H. Douthwaite, editor—*French's Index of Differential Diagnosis*. 7th ed. Williams & Wilkins Company, Balt., 1954.

T. R. Harrison & others, editors—*Principles of Internal Medicine*. 2nd ed. Blakiston Company, Inc., N.Y., 1954.

Goodrich C. Schauffler—*Pediatric Gynecology with Sections on Urology and Proctology*. 3rd ed. Year Book Publishers, Inc., Chic., 1953.

*Surgical Forum. Proceedings of the Forum Sessions, Thirty-ninth Clinical Congress of the American College of Surgeons, Chicago, Illinois, October 1953*. W. B. Saunders Company, Phil., 1954.

Meyer Texon—*Heart Disease and Industry with particular reference to Workmen's Compensation cases*. Grune & Stratton, N.Y., 1954.

*Year Book of Endocrinology (1953-1954 Year Book Series)*. Edited by Gilbert S. Gordan. Year Book Publishers, Inc., Chic., 1954.

*Year Book of Medicine (1954-1955 Year Book Series)*. Edited by Paul B. Beeson & others. Year Book Publishers, Inc., Chic., 1954.

*Year Book of Pathology and Clinical Pathology (1953-1954 Year Book Series)*. Edited by William B. Wartman. Year Book Publishers, Inc., Chic., 1954.

*Two books were added to the Gormly collection:*  
Henry A. Davidson—*Forensic Psychiatry*. The Ronald Press Company, N.Y., 1952.

Thomas A. Gonzales & others—*Legal Medicine, Pathology and Toxicology*. 2nd ed. Appleton-Century-Crofts, Inc., N.Y., 1954.

*The following title has been added to the Veterinary collection:*

Franz Hutyra, Joseph Marek & Rudolph Manninger—*Special Pathology and Therapeutics of the Diseases of Domestic Animals*. 5th English ed., Alexander Eger Inc., Chic., 1949. 3 vols.

*Other purchases:*

National Health Council. *Directory of Member Organizations*. N.Y., 1954.

Leon E. Page—*The Principles of Osteopathy*. Kansas City, Mo., 1952.

David Patten—*Rhode Island Story. Recollections of 35 Years on the Staff of the Providence Journal and the Evening Bulletin*. Prov., 1954.

*Subject Heading Authority List used by the Current List Division, Armed Forces Medical Library*. Wash., 1954.

*Review volumes received from the Rhode Island Medical Journal were:*

Harry Bakwin & Ruth Morris Bakwin—*Clinical Management of Behavior Disorders in Children*. W. B. Saunders Company, Phil., 1953.

Sam W. Banks & Harold Laufman—*An Atlas of Surgical Exposures of the Extremities*. W. B. Saunders Company, Phil., 1953.

Meredith Campbell, editor—*Urology*. 3 vols. W. B. Saunders Company, Phil., 1954.

Richard B. Cattell & Kenneth W. Warren—*Surgery of the Pancreas*. W. B. Saunders Company, Phil., 1954.

Charles G. Child, III—*The Hepatic Circulation and Portal Hypertension*. W. B. Saunders Company, Phil., 1954.

Norman F. Conant & others—*Manual of Clinical Mycology*. 2nd ed. W. B. Saunders Company, Phil., 1954.

*continued on page 690*



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**DOSEAGE:** The usual dose of Theominal R.S. is 1 tablet two or three times daily. When improvement has been maintained for a time, the dose may be reduced or medication suspended occasionally until its resumption is indicated.

**HOW SUPPLIED:** Theominal R.S. is supplied in bottles of 100 tablets.





For truly healthful sleeping comfort, Sealy has created an entirely new mattress, designed in cooperation with leading Orthopedic surgeons. The patented Posturepedic coil, "heart" of Sealy's superior support, aids true spine-on-a-line sleeping posture. See the completely different Sealy Posturepedic today.

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# **RHODE ISLAND MEDICAL JOURNAL ON THE MEDICAL LIBRARY BOOKSHELVES**

*continued from page 688*

- Howard F. Conn, editor—Current Therapy 1954. W. B. Saunders Company, Phil., 1954.
- Thomas Flint, Jr.—Emergency Treatment and Management. W. B. Saunders Company, Phil., 1954.
- Sir Howard Florey, editor—Lectures on General Pathology. W. B. Saunders Company, Phil., 1954.
- Anna Davis Hunt—Letters to a Doctor's Secretary. Medical Economics, Rutherford, N.J., 1952.
- Alfred C. Kinsey & others—Sexual Behavior in the Human Female. W. B. Saunders Company, Phil., 1953.
- Frederick Lee Liebolt—Illustrated Review of Fracture Treatment. Lange Medical Publications, Los Altos, 1954.
- Gustav J. Martin—Biological Antagonism. The Theory of Biological Relativity. Blakiston Company, 1951.
- Mayo Clinic Diet Manual by the Committee on Dietetics of the Mayo Clinic. 2nd ed. W. B. Saunders Company, Phil., 1954.
- Samuel Raynor Meaker—A Doctor Talks to Women. Simon and Schuster, N.Y., 1954.
- Waldo E. Nelson, editor—Textbook of Pediatrics. 6th ed. W. B. Saunders Company, Phil., 1954.
- Adolf Nichtenhauser, Marie L. Coleman & David S. Ruhe—Films in Psychiatry, Psychology & Mental Health. Health Education Council, N.Y., 1953.
- Arthur P. Noyes—Modern Clinical Psychiatry. 4th ed. W. B. Saunders Company, Phil., 1953.
- Langdon Parsons & Howard Ulfelder—An Atlas of Pelvic Operations. W. B. Saunders Company, Phil., 1953.
- Proceedings of the 35th Conference of the Child Research Clinic of the Woods Schools, held in Philadelphia, May 23, 1953. "The Pre-adolescent Exceptional Child." Langhorne, Pa., 1953.
- Report of the Medical Research Council for the Year 1952-1953. Lond., 1954.
- Frank H. Richardson—The Nursing Mother. A Guide to Successful Breast Feeding. Prentice-Hall, Inc., N.Y., 1953.
- Howard A. Rusk, Eugene J. Taylor & others—Living with a Disability. Blakiston Company, Inc., N.Y., 1953.
- Eliot Slater—Psychotic and Neurotic Illnesses in Twins. Medical Research Council Special Report Series, No. 278. Lond., 1953.
- Josef S. Smul—Respiratory Diseases and Allergy. New Method of Approach. Medical Library Company, N.Y., 1953.
- We have had many gifts of books, pamphlets and journals. Some of the titles are:*
- American Cancer Society—Collected Reprints. 4 vols. N.Y., 1954 (for 1952).
- Louis H. Bauer, editor—Seventy-five Years of

Medical Progress. 1878-1953. Lea & Febiger, Phil., 1954. Gift of Dr. Peter P. Chase.

Walter L. Bierring—The History of Medicine of Polk County, Iowa. Des Moines, 1951. Gift of the Polk County Medical Society.

The Clinical Conferences of St. Michael's Hospital, Newark, New Jersey. Vol. III, 1952-1953.

Collected Studies from Chicago Municipal Tuberculosis Sanitarium Research Laboratory. Vol. IX, 1950-1953.

Conference Papers Presented before the Ninth Clinical Conference of the Chicago Medical Society, March 3, 4, 5, 6, 1953. Official Bulletin Publishing Co., Chic., 1954.

Ernest E. Irons—The Story of Rush Medical College. Chic., 1953. Gift of the Trustees of Rush Medical College.

Francis D. W. Lukens, editor—Medical Uses of Cortisone including Hydrocortisone and Corticotropin. Blakiston Company, Inc., N.Y., 1954. Gift of Merck & Co., Inc.

National Foundation for Infantile Paralysis—Collected Reprints of the Grantees. Vol. XIV, pts. 1 & 2, 1953. N.Y., 1954.

National Organization of Hospital Schools of Nursing—A Study of the Educational Programs of Hospital Schools of Nursing. Decatur, Ga., 1954.

New and Nonofficial Remedies Accepted by the Council on Pharmacy and Chemistry. J. B. Lippincott Company, Phil., 1954. Gift of the American Medical Association.

Proceedings of the Fifth Annual Conference on the Nephrotic Syndrome held at the Children's Hospital, Philadelphia, Pa., November 5-7, 1953.

Proceedings of the Forty-seventh Annual Meeting of Life Insurance Association of America, New York, December 8, 9, 1953.

Berton Roueche—Eleven Blue Men and Other Narratives of Medical Detection. Little, Brown and Company, Bost., 1953. Gift of Dr. F. Ronchese.

Studies from the Rockefeller Institute for Medical Research. Reprints. Vol. 148, N.Y., 1954.

Symposium on the Laboratory Propagation and Detection of the Agent of Hepatitis, New York City, 31 March 1954. National Academy of Sciences—National Research Council, Wash., 1954.

Transactions of the American Association of Genito-urinary Surgeons, Vol. XLV, 1953. Williams & Wilkins Co., Balt., 1954.

Transactions of the New England Obstetrical and Gynecological Society, Vol. VII, 1953. Gift of Dr. H. G. Partridge.

Transactions of the New England Surgical Society, Thirty-fourth Meeting, Vol. XXXIV, 1953. Gift of Dr. Peter P. Chase.

Transactions of the Southeastern Section of the American Urological Association, Seventeenth An-

*continued on next page*

## PHYSICIAN *Cure Thyself*

**It has been said  
that he who treats himself  
has a fool for a patient  
and a fool for a doctor.**

**But like all adages  
this one has an exception  
that proves the rule.**

**For if, Doctor,  
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with too many germs  
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here is a prescription  
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**Treat yourself  
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next Wednesday  
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**See, you're feeling better  
already.**

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nual Meeting, Havana, Cuba, March 26-29, 1953. Transactions of the Western Section of the American Urological Association, Vol. 20, 1953.

Transactions of the 13th Conference on the Chemotherapy of Tuberculosis held on February 8 to 11, 1954 at the St. Louis Medical Society, St. Louis, Mo., by the Veterans Administration, Army, Navy, with the Cooperation of the National Tuberculosis Association.

University of Pennsylvania. Thirty-fourth Report of the Henry Phipps Institute for the Study, Treatment and Prevention of Tuberculosis, 1952, 1953. Phil., 1954.

Veterans Administration Technical Bulletins Series 10. Vol. VI, 1952 and 1953. Wash., 1954.

Shields Warren & William A. Meissner—Tumors of the Thyroid Gland. Wash., 1953. Gift of the R. I. Cancer Society, Inc.

Fredrick F. Yonkman & others—Reserpine (serpasil) and other Alkaloids of Rauwolfia Serpentina: Chemistry, Pharmacology, and Clinical Applications. Ann. N.Y. Acad. Sciences, vol. 59, art. 1, pages 1-140, 1954. Gift of Mr. Morton Saunders, Ciba Pharmaceutical Products, Inc.

Dr. H. G. Partridge has given us five more books from his collection:

William Macmichael—The Gold-Headed Cane. 2nd ed., Lond., 1828. This gives us the first through fifth editions of this important work.

Henry a Daventer (Hendrik van Deventer)—The Art of Midwifery Improv'd . . . Lond. 1716. The author is famous for his accurate description of the "bony structure of the pelvis, its deformities, and the effect they had on labour" (Graham—Eternal Eve).

Mme. Le Boursier du Coudray—Abrege de l'Art des Accouchements, . . . Chalons-sur-Marne, 1773. This book, by a famous midwife of Paris, is remarkable for its fine plates, engraved in several colors.

George J. Engelmann—Labor Among Primitive Peoples . . . 3rd ed. St.L., 1884. Garrison calls this "an anthropological classic."

E. A. Andrews—A Copious and Critical Latin-English Lexicon, founded on the Larger Latin-German Lexicon by Dr. William Freund . . . N.Y., 1851. The Lexicon was used by Dr. Partridge's father and by Dr. Partridge; it was given to our Library to help the librarian translate the Latin titles of old dissertations and theses.

#### **Books Received**

The receipt of the following books is acknowledged, and the Editor thanks the publishers for their courtesy in sending them. These volumes are available in the Library.

Report of the Medical Research Council for the Year 1952-1953. Her Majesty's Stationery Office, Lond., 1954. \$1.70

#### **RHODE ISLAND MEDICAL JOURNAL**

New and Nonofficial Remedies Accepted by the Council on Pharmacy and Chemistry, 1954. J. B. Lippincott Company, Phil., 1954

Eliot Slater—Psychotic and Neurotic Illnesses in Twins. Medical Research Council Special Report Series No. 278. Her Majesty's Stationery Office, Lond. 1953. \$4.75

Joseph S. Smul—Respiratory Diseases and Allergy. New Method of Approach. Medical Library Company, N.Y., 1953. \$2.75

Malford W. Thewlis and Isabelle Clark Swezy—Handwriting and the Emotions. American Graphological Society, Inc., N.Y., 1954. \$8.00

#### **MISSING**

*American Heart Journal*, October 1953

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*It is another of the more than 30 organisms susceptible to*

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## IMPORTANT MEDICAL MEETINGS IN 1955

*Clip out this page and save for future reference*

### LOCAL

RHODE ISLAND MEDICAL SOCIETY, at Providence, May 4 and 5  
PROVIDENCE MEDICAL ASSOCIATION, at Providence, January 3, February 7, March 7, April 4, October 3, November 7, and December 5

### NEW ENGLAND

AMERICAN COLLEGE OF SURGEONS, Regional Meeting, at Providence, March 3-4-5  
AMERICAN UROLOGICAL ASSOCIATION (Regional Meeting), at Lake Placid, N. Y., Sept. 22-24  
NEW ENGLAND HOSPITAL ASSEMBLY, at Boston, March 28-30  
NEW ENGLAND POSTGRADUATE ASSEMBLY, at Boston, October 24-26  
CONNECTICUT STATE MEDICAL SOCIETY, at Stratford, April 26-28  
MASSACHUSETTS MEDICAL SOCIETY, at Boston, May 17-19  
MAINE MEDICAL ASSOCIATION, at Rockland, June 19-21  
NEW HAMPSHIRE AND VERMONT STATE MEDICAL ASSOCIATIONS, at Bretton Woods, N. H., Sept. 29-Oct. 1

### NATIONAL

AMERICAN MEDICAL ASSOCIATION, at Atlantic City, June 6-10.  
AMERICAN MEDICAL ASSOCIATION (Clinical Session), at Boston, Nov. 29-Dec. 2  
AMERICAN COLLEGE OF PHYSICIANS, at Philadelphia, April 25-29  
AMERICAN COLLEGE OF SURGEONS, at Chicago, Oct. 30-Nov. 4  
INDUSTRIAL MEDICAL ASSOCIATION, at Buffalo, April 23-30  
INTERNATIONAL COLLEGE OF SURGEONS, at Philadelphia, Sept. 12-15  
AMERICAN ACADEMY OF ALLERGY, at New York City, Feb. 7-9  
AMERICAN COLLEGE OF ALLERGISTS, at Chicago, April 25-30  
AMERICAN SOCIETY OF ANESTHESIOLOGY, at Boston, Oct. 30-Nov. 3

AMERICAN COLLEGE OF CHEST PHYSICIANS, at Atlantic City, June 2-5  
AMERICAN SOCIETY OF CLINICAL INVESTIGATION, at Atlantic City, May 1-3  
AMERICAN ACADEMY OF GENERAL PRACTICE, at Los Angeles, Mar. 28-31  
AMERICAN HEART ASSOCIATION, at New Orleans, Oct. 22-27  
AMERICAN ACADEMY OF OBSTETRICS AND GYNECOLOGY, at Chicago, Dec. 12-14  
AMERICAN ACADEMY OF PEDIATRICS, at Chicago, Oct. 1-6  
AMERICAN ACADEMY OF PEDIATRICS (Spring Session), at Detroit, April 4-6  
AMERICAN PSYCHIATRIC ASSOCIATION, at Atlantic City, May 9-12  
AMERICAN PUBLIC HEALTH ASSOCIATION, at Kansas City, Nov. 14-18

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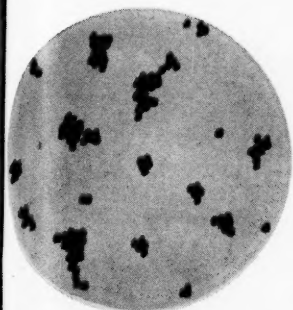
Graduate of Medical College of Virginia School of Physical Therapy

Employed in the department of Physical Medicine and Rehabilitation in a Providence hospital  
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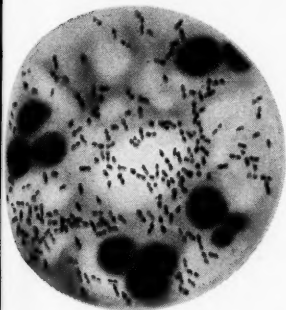
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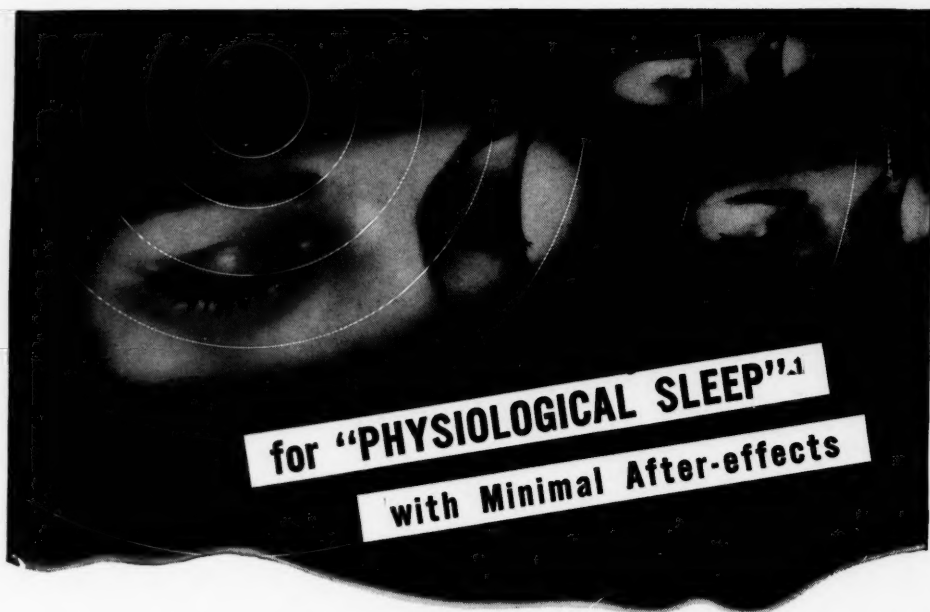
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CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.



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Goodman and Gilman observe that it "is unfortunately neglected today," and that the present widespread use of the barbiturates has "... caused the physician to lose sight of the fact that chloral hydrate is still one of the cheapest and most effective hypnotics."<sup>2</sup>

In FELLO-SED, supplementation with calcium bromide and atropine sulfate largely overcomes unwanted side-actions, enhances the sedative effect and provides valuable antispasmodic activity. It is presented in palatable liquid form.

<sup>1</sup>N.N.R., 1947, p. 398.

<sup>2</sup>Goodman, L. & Gilman, A., The Pharmacological Basis of Therapeutics. MacMillan, 1944, pp. 177-8.

Available in 8 fluidounce bottles.

*Adult Dose: As a sedative: ½ to 1 teaspoonful with water, every 3 or 4 hours or as directed. As a hypnotic, 1 to 2 teaspoonfuls or more with water at bedtime, or as directed.*

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**FORMULA:** Each fluidram (4 cc.) contains, in a palatable aromatic vehicle: Chloral Hydrate, 0.5 Gm. (7½ gr.); Calcium Bromide, 0.5 Gm. (7½ gr.); Atropine Sulfate, (1/480 gr.).

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*Staphylococcus aureus* (*Micrococcus pyogenes* var. *aureus*) is a Gram-positive organism commonly involved in a great variety of pathologic conditions, including

pyoderma • abscesses • empyema • otitis • sinusitis • septicemia  
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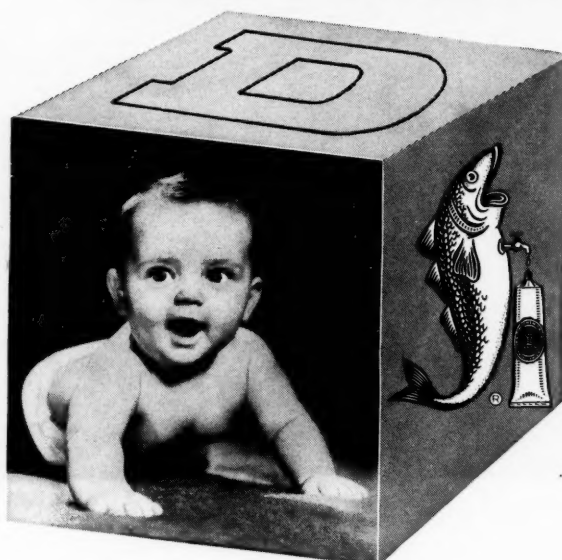
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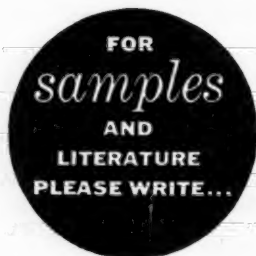
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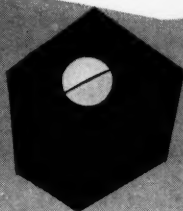
1. Grayzel, H. G., Helmer, C. B., and Grayzel, R. W.: New York St. J. M. 53:2233, 1953.
2. Helmer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951.
3. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surgery 18:512, 1949.
4. Turell, R.: New York St. J. M. 50:2282, 1950.

**Combination tranquilizer-antihypertensive**

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Streptococcus faecalis is a Gram-positive organism commonly involved in  
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'Thorazine' "stopped hiccup in five of seven patients treated and partially controlled it in the other two." (Stewart and Redecker: *California Med.* 81:203, Sept., 1954.)

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Chemically it is 10-(3-dimethylaminopropyl)-2-chlorphenothiazine hydrochloride.

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The stillness of water, the peace, the deep repose.

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**For continuous mild sedation  
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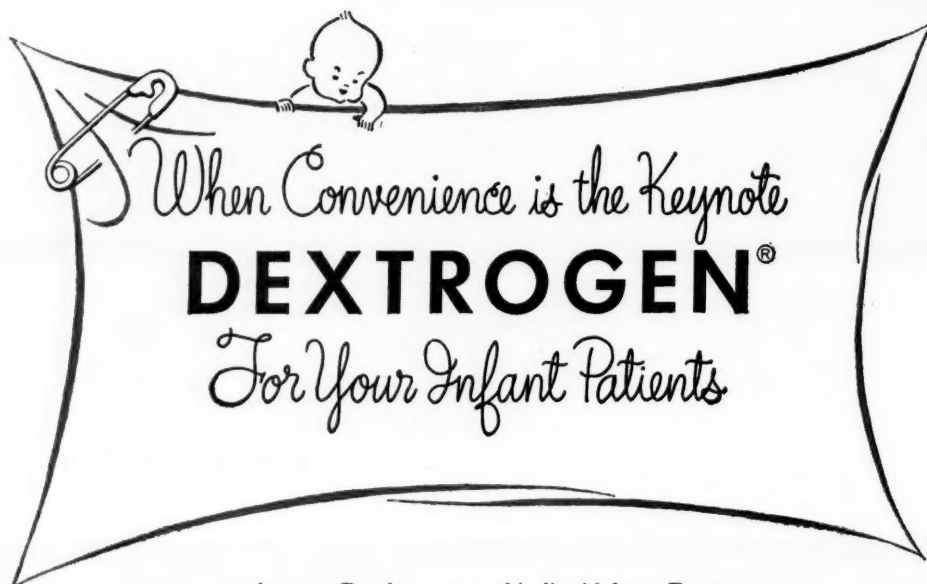
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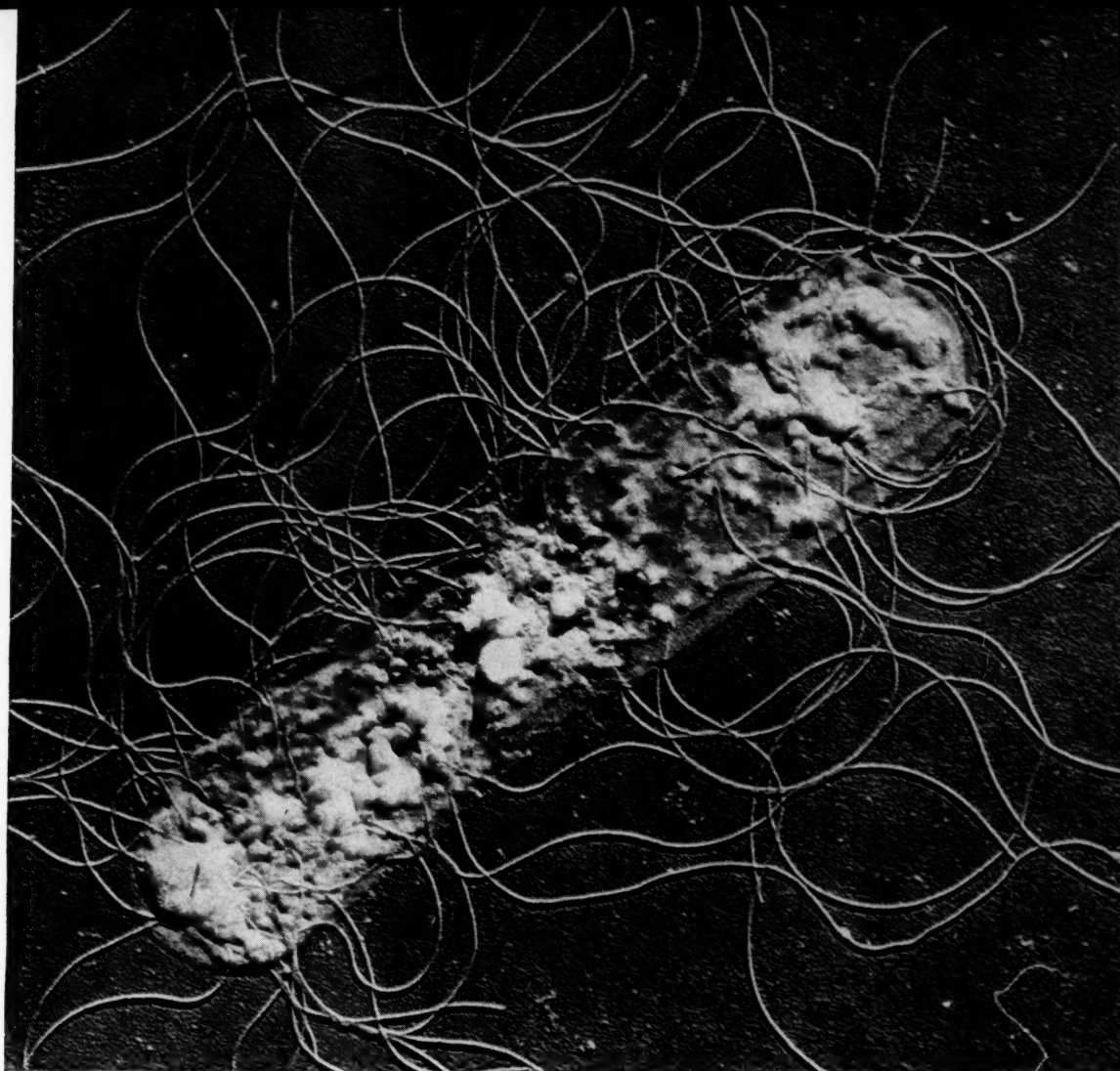
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1. Kline, P. R., and Caldwell, A.:  
New York St. J. M. May 1, 1952.
2. Combes, F. C., and Zuckerman, R.:  
J. Invest. Dermat. 16:379, 1951.
3. Kline, P. R.: Current News in  
Derm. & Syph., May 1952.

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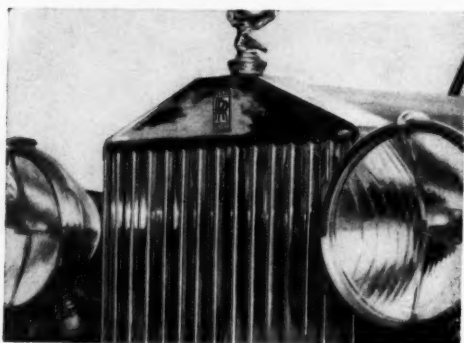
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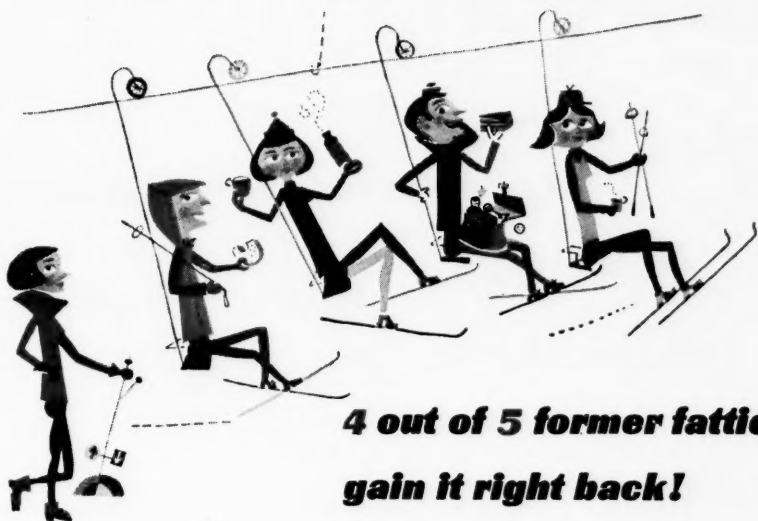


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